

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10103

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in my event within 24 hours after death.

10137

1. PLACE OF DEATH

a. COUNTY

CARROLL

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

NEW WINDSOR RURAL

c. LENGTH OF STAY IN lb

YEARS

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

MARYLAND

b. COUNTY

CARROLL

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

NEW WINDSOR RURAL

d. STREET ADDRESS

e. IS RESIDENCE
ON A FARM?
YES NO

3. NAME OF
DECEASED
(Type or print)

First
DELLA

Middle
MAE

Last
BARBER

4. DATE
OF
DEATH

Month
SEPT

Day
1

Year
1960

5. SEX

F

W

6. COLOR OR RACE

WIDOWED

7. MARRIED

NEVER MARRIED

8. DATE OF BIRTH

DIVORCED

9. AGE (In years
last birthday)

JAN 18-1881

10. IF UNDER 1 YEAR

Months
79

11. IF UNDER 24 HRS.

Days
yrs.

Hours
Min.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY

OWN HOME

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

THOMAS LIPPY

14. MOTHER'S MAIDEN NAME

JANE HARRIS

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)
(If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

NYONE

17. INFORMANT

GEORGE BARBER

RURAL

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

9000

DUE TO

Fractured skull

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

Arterio Sclerosis (Genl) w/aged
changes

DUE TO

(c)

Hypertension & Cardio Vascular
disease

INTERVAL BETWEEN
ONSET AND DEATH

15 hrs

several

yes

no

19. WAS AUTOPSY
PERFORMED?
YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH.

20c. TIME OF INJURY

Month, Day, Year

Hour
8:00 a. m.

8/31 1960

8:00 p. m.

20b. INJURY OCCURRED

While
at work

Not while
at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

HOME

(County)

Rox

(State)

Westminster Carroll MD

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

W. Glyn Speicher

Westminster MD

M.D. CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

9/1/60

22a. BURIAL, CREMATION,
REMOVAL (Specify)

BURIAL

22b. DATE THEREOF

9/4/60

22c. NAME OF CEMETERY OR CREMATORIUM

LEISTER'S

22d. LOCATION (City, town, or county)

WESTMINSTER RURAL MD

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

D. Hartzler & Son, New Windsor

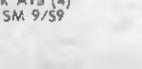
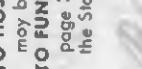
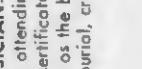
ADDRESS

24a. REC'D BY REGISTRAR

Sept 6 '60

24b. REGISTRAR'S SIGNATURE

Arthur S. Fournier



TO HOSPITAL may be referred by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10139

CERTIFICATE OF DEATH

Reg. Dist. No. 10105

| | | | | | | | | |
|---|--|---|--|---|--|---|--------------------------|----------------|
| 1. PLACE OF DEATH a. COUNTY | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE | | Maryland | | |
| Carroll | | | | b. COUNTY | | Carroll | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hampstead | | c. LENGTH OF STAY IN lb 3640 | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hampstead | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hillcrest. | | d. STREET ADDRESS Hillcrest | | e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) | | First Clinton | Middle Bayard | Last Bollinger | 4. DATE OF DEATH | Month September | Day 26 | Year 1960 |
| 5. SEX Male | | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH JAN. 22, 1891 | 9. AGE (In years last birthday) 69 yrs. | IF UNDER 1 YEAR Months | IF UNDER 24 HRS. Days | Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Body Builders. | | 10b. KIND OF BUSINESS OR INDUSTRY Truck Bodies | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME George Bollinger | | 14. MOTHER'S MOTHER'S NAME Elisia Wilhelme | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 215-10-1186 | | INFORMANT Mrs. Lottie M. Bollinger | | Address Hampstead Md. | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] Part I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | DUE TO Condition, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | Carcinomatosis, Generalized Primary Carcinoma Penis | | INTERVAL BETWEEN ONSET AND DEATH (?) 19 Months | | |
| (b) | | DUE TO | | | | | | |
| (c) | | | | | | | | |
| Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ 19 p. m. _____ | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) _____ |
| | | | | | | | | (State) _____ |
| 21. I certify that I attended the deceased from 6-25, 1958, to Sept 26, 1960, that I last saw the deceased alive on 6-24, 1960, and the death occurred at 6A M, from the causes and on the date stated above. | | | | | | ADDRESS (Street, city or town, state) _____ DATE SIGNED 9/26/60 | | |
| ACTUAL SIGNATURE Joseph E. Bush M.D. | | | | | | | | |
| PHYSICIAN'S NAME (Type) Joseph E. Bush MD | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 9-28-60 | | 22c. NAME OF CEMETERY OR CREMATORIAL St. Peters | | 22d. LOCATION (City, town, or county) Baltimore Md. (State) | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Edee S. Tipton | | ADDRESS Hampstead Md. | | 24a. REC'D BY REGISTRAR SEP 30 '60 DATE | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kline | | |

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10106

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Carroll | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural—Sykesville | | c. LENGTH OF STAY IN 1b 19y.10m.23d. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | First Emma | Middle V. | 4. DATE OF DEATH Month 9 Day 15 Year 1960 |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 4/9/77 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Maryland |
| 13. FATHER'S NAME Theodore Lerp | | 14. MOTHER'S MAIDEN NAME Catherine Henkle | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. | 17. INFORMANT Springfield Hospital records, Sykesville, Md. |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420-1 Acute myocardial infarction | | Minutes | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary arteriosclerosis | | Years | |
| DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 10/22/1960 to 9/15/1960 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 9/15/1960 , and that death occurred at 10: M. from the causes and on the date stated above. | | 22b. DATE SIGNED 9/16/60 | |
| 22a. SIGNATURE Konstantin Weber M. D. | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | |
| 22c. PHYSICIAN'S NAME (Type) Konstantin Weber, M. D. | | 22d. ADDRESS Springfield State Hospital Sykesville, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 9/27/60 | |
| 23c. NAME OF CEMETERY OR CREMATORIAL Western Cem. | | 23d. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE John J. Trickey & Sons - Part 17 | | 25a. REC'D BY REGISTRAR DATE SEP 28 '60 | 25b. REGISTRAR'S SIGNATURE Arthur J. Trickey |

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

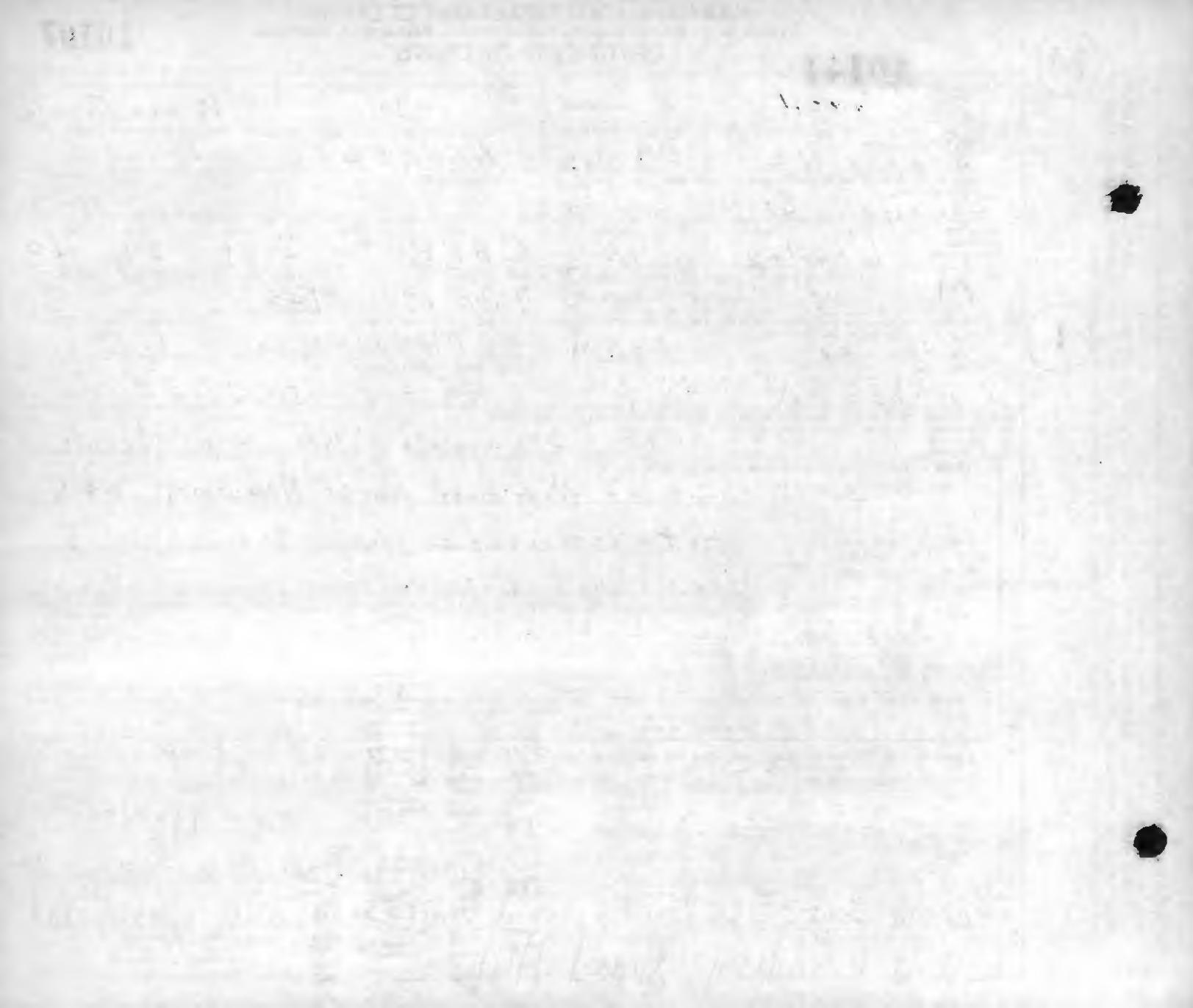
10107

M

| | | | | | | | | | |
|---|--|--|---|--|---|---|------------------------------|---|---------|
| 1. PLACE OF DEATH a. COUNTY | | 10141 Carroll | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE | | MD. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | d. STREET ADDRESS | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| SYKESVILLE | | 29 yrs. | | LAUREL | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | Springfield State Hospital | | d. STREET ADDRESS | | | | | |
| 3. NAME OF DECEASED (Type or print) | | First | Middle | Last | 4. DATE OF DEATH | Month | Day | Year | |
| Charles | | W. | | CARR | Sept. | 27 | 1960 | | |
| 5. SEX | | 6. COLOR OR RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | B. DATE OF BIRTH | 9. AGE (in years at death/birth) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | | |
| M | | W. | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 7 Nov. 1900 | 59 yrs. | Months | Days | Hours | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | |
| Laborer | | | FARM | | MARYLAND | | U.S. | | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | | | | | |
| CHARLES R. CARR | | | HATTIE BOSLEY | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | | |
| NO | | NONE | | Springfield State Hosp. Records | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ruptured Abdominal Aorta Aneurysm 11 HRS. | | | | | | | | | |
| 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) Arteriosclerotic Heart Disease Yrs. | | | | | | | | | |
| DUE TO (c) Generalized Arteriosclerosis Yrs. | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | |
| Schizophrenic - Pulmonary Tbc. 002X | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Hour o. m. p. m. | | Month | Day | Year | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) |
| 19 | | | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 5 MARCH 1931, to 27 Sept. 1960, that (I) (we) last saw the deceased alive on 22 nd 1960, and that death occurred at 22 nd p.m., from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE | | | | | | | | | |
| 22b. DATE SIGNED 9/27/60 | | | | | | | | | |
| 22c. PHYSICIAN'S NAME (Type) | | 22d. ADDRESS | | Springfield State Hosp. Sykesville Md. | | | | | |
| Burial, Cremation, Removal (Specify) | | 23b. DATE THEREOF | | 23c. NAME OF CEMETERY OR CREATOR | | 23d. LOCATION (City, town, or county) | | (State) | |
| Burial Sept 30 60 | | 24. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | | 25c. REC'D. BY REGISTRAR DCT 5 '60 | | 25b. REGISTRAR'S SIGNATURE Charles S. Kraus | |

ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be read by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10108.

CERTIFICATE OF DEATH

10142

| | | | | | | | | | |
|---|--|--|---|---|---|---|-------------------------------|-----------------------------|---------|
| 1 PLACE OF DEATH a. COUNTY Carroll | | MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland | | b. COUNTY Frederick | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Henryton | | c. LENGTH OF STAY IN 1b 22 days | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick | | d. STREET ADDRESS 412 Middle Alley | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital | | | | | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3 NAME OF DECEASED (Type or print) Monroe | | First | Middle | Last | 4. DATE OF DEATH Carter | Month | Day | Year | |
| 5 SEX Male | | 6. COLOR OR RACE Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 12-17-05 | | 9. AGE (In years lost birthday) 54 | 10. IF UNDER 1 YEAR Months | 11. IF UNDER 24 HRS Days | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (State or foreign country) New Orleans, La. | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | | |
| 13. FATHER'S NAME Charlie Carter | | | | 14. MOTHER'S MAIDEN NAME Cora Bell | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No | | 16. SOCIAL SECURITY NO. 429-07-3480 | | 17. INFORMANT Monroe Carter - Patient | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] Cardiovascular Insufficiency Uremia and Moderately advanced Tbc. Chronic glomerulonephritis | | | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 008 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) | | | | | | | | | |
| DUE TO (b) (c) | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | | | | | | | |
| 20c. TIME OF INJURY Hour o. m. p. m. | | Month 19 | Day | Year | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) |
| 21. I certify that (I) (this hospital) attended the deceased from Aug. 18, 1960 to Sept. 9, 1960 that (I) (we) last saw the deceased alive on Sept. 9, 1960 and that death occurred at 4:30A from the causes and on the date stated above | | | | | | | | | |
| 22a. SIGNATURE Edgars M. Maculans | | M D | | ATTENDING PHYS. <input type="checkbox"/> | MED. DIRECTOR <input checked="" type="checkbox"/> | STAFF PHYS. <input type="checkbox"/> | 22b. DATE SIGNED 2060 | | |
| 22c. PHYSICIAN'S NAME (Type) Dr. Edgars M. Maculans, Supt. | | 22d. ADDRESS | | Henryton State Hospital, Henryton, Md. | | | | | |
| 23a. BURIAL, CREMATION, REBURNAL (Check if applicable) REBURNAL | | 23b. DATE THEREOF 9-14-1960 | | 23c. NAME OF CEMETERY OR CREMATORIUM Mount Auburn | | 23d. LOCATION (City, town, or county) Baltimore, Maryland | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE J. W. Saunders | | 24. ADDRESS 24 All Saints St. | | 25a. REC'D BY REGISTRAR Charles E. Hicks III | | 25b. REGISTRAR'S SIGNATURE miss L. Hunt | | | |
| VR A15 (4) 1SM 9/59 | | | | DATE SEP 16 '60 | | | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10128

CERTIFICATE OF DEATH

Reg. Dist. No.

10109

TO HOSPITAL: may be referred by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 4

| | | | |
|--|---------------|--|------------------------------|
| 1. PLACE OF DEATH a. COUNTY <i>Carroll</i> | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE <i>Maryland</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Manchester</i> | | c. LENGTH OF STAY IN 1b <i>15 yrs</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>227 E Main</i> | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Manchester</i> | |
| 3. NAME OF DECEASED (Type or print) <i>HOWARD - A - CLAS</i> | | d. STREET ADDRESS <i>227 E Main</i> | |
| 4. DATE OF DEATH <i>Sept 15 1960</i> | Month Year | 5. SEX <i>M</i> | 6. COLOR OR RACE <i>W</i> |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <i>July 26-1893</i> | | 9. AGE (In years last birthday) <i>67 yrs</i> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Guard</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Black & Decker</i> | |
| 11. BIRTHPLACE (State or foreign country) <i>Md</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 13. FATHER'S NAME <i>Charles Glas.</i> | | 14. MOTHER'S MAIDEN NAME <i>Margaret Theriot</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> | | 16. SOCIAL SECURITY NO <i>220-05-1220</i> | |
| 17. INFORMANT <i>W. Howard Glas</i> | | Address <i>Manchester, Md</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>33 IX</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>5 min</i> | |
| DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c) | | Cerebral hemorrhage (reurrent) Generalized Arteriosclerosis <i>5 yrs</i> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>myocardial infarction</i> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING TO CAUSE OF DEATH (If either, not by MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <i>1957</i> | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>Mount</i> , 19 <i>51</i> , to <i>Sept 15</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>Sept 15</i> , 19 <i>60</i> , and that death occurred at <i>63</i> M. from the causes and on the date stated above. ACTUAL SIGNATURE <i>W. Howard</i> | | ADDRESS (Street, city or town, state) <i>Manchester, Md</i> DATE SIGNED <i>Sept 16 1960</i> | |
| PHYSICIAN'S NAME (Type) <i>W. H. Howard M.D.</i> | | 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | |
| 22b. DATE THEREOF <i>9-18-1960</i> | | 22c. NAME OF CEMETERY OR CREMATORIAL <i>Manchester</i> | |
| 22d. LOCATION (City, town, or county) <i>Carroll Co Md</i> | | 23. FUNERAL DIRECTOR'S SIGNATURE <i>Edie Clifton</i> | |
| 24a. REC'D BY REGISTRAR <i>Arthur S. Kraus</i> | | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i> | |
| VS A15 (4) 15M 9/58 | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film G272 10-3-60 et

10131

CERTIFICATE OF DEATH

Reg. Dist. No.

10110

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | | |
|---|---------------------------|---|--|---|--|--|---|-----------------------------|
| 1. PLACE OF DEATH a. COUNTY Carroll | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland | | b. COUNTY Carroll | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster | | c. LENGTH OF STAY IN 1b 46 yrs. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster | | d. STREET ADDRESS 99½ Liberty Street | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 99½ Liberty Street | | | | d. STREET ADDRESS 99½ Liberty Street | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) George | | First | Middle | Last | 4. DATE OF DEATH Sept. 24 | Month | Day | Year 19 60 |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH 3/17/1883 | 9. AGE (in years lost birthday) 75 yrs | IF UNDER 1 YEAR Months | IF UNDER 24 HRS Days | Address Westminster, Md. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Army, retired | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Carroll Co., Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME Joseph C. Close | | 14. MOTHER'S MAIDEN NAME Annie Fisher | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) yes | | 16. SOCIAL SECURITY NO. World War I 215-20-8612 | | INFORMANT Mervin E. Close | | Address 99½ Liberty St. Westminster, Md. | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) | | Carcinoma Bladder, anemia a cachexia ileocecal Esophagus Colon Arturia salivosis 2nd | | INTERVAL BETWEEN ONSET AND DEATH 3-4 yrs | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. | | 19 | 20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) | |
| 21. I certify that I attended the deceased from <u>June 29, 1960</u> to <u>Sept 24, 1960</u> that I last saw the deceased alive on <u>Sept 24, 1960</u> and that death occurred at <u>4:30 PM</u> , from the causes and on the date stated above | | | | ADDRESS (Street, city or town, etc.) | | | DATE SIGNED | |
| ACTUAL SIGNATURE W. L. Myers | | | | | | | | |
| PHYSICIAN'S NAME (Type) Burial | | 22b. DATE THEREOF Sept. 28, 1960 | | 22c. NAME OF CEMETERY OR CREMATORY National Cemetery | | 22d. LOCATION (City, town, or county) Baltimore | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE X. L. Myers | | ADDRESS Westminster, Md. | | 24a. REC'D BY REGISTRAR Date SEP 28 '60 | | 24b. REGISTRAR'S SIGNATURE C. L. Myers | | |



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1014

CERTIFICATE OF DEATH

10111

| | | | |
|---|-----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Carroll | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodbine | | c. LENGTH OF STAY IN 1b Life | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodbine | |
| d. STREET ADDRESS | | d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) BENJAMIN | | First F. | Middle CONDON |
| Last | | 4. DATE OF DEATH Month September Day 10, Year 1960 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | B DATE OF BIRTH January 12, 1890 |
| WIDOWED <input type="checkbox"/> | DIVORCED <input type="checkbox"/> | 9. AGE (In years last birthday) 70 yrs | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter | | 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | 13. FATHER'S NAME Sommerville Condon | |
| 14. MOTHER'S MAIDEN NAME Susannah Pickett | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | |
| 16. SOCIAL SECURITY NO W.W. 1 | | 17. INFORMANT Augustus Condon, Woodbine, Maryland | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis, Atherosclerosis | | INTERVAL BETWEEN ONSET AND DEATH 1956 | |
| 4. Condit. ans. if any, which gave rise to immediate cause (a), stating the underlying cause last. | | DUE TO Heart disease, atherosclerosis | |
| | | DUE TO to | |
| | | DUE TO 1960 | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 1956 to 10 Sept 1960 , that (I) (we) last saw the deceased alive on 10 Sept 1960 , and that death occurred at 8:30 A.M. from the causes and on the date stated above. | | 22b. DATE SIGNED 10 Sept 1960 | |
| 22c. SIGNATURE Howard E. Hall | | M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | |
| 22c. PHYSICIAN'S NAME (Type) Howard E. Hall M. D., | | 22d. ADDRESS Sykesville, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Sept. 13, 1960 | |
| 23c. NAME OF CEMETERY OR CEMATORIUM Taylorsville | | 23d. LOCATION (City, town, or county) (State) Carroll Co., Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz, Winfield, Maryland | | 25a. REC'D BY REGISTRAR DATE SEP 14 '60 | |
| ADDRESS | | 25b. REGISTRAR'S SIGNATURE Charles S. Kline | |

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MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10112

| | | | | | | | | | |
|---|------------------|--|---|--|---------------------------------------|--|---------------------|---------|------|
| 1. PLACE OF DEATH a. COUNTY | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. LENGTH OF STAY IN 1b | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) | | | |
| Carroll | | Maryland | | 57y.8m.19d. | | a. STATE Maryland | | | |
| Rural - Sykesville | | | | | | b. COUNTY 1 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | | | | |
| Springfield State Hospital | | | | Baltimore | | d. STREET ADDRESS | | | |
| 3. NAME OF DECEASED (Type or print) | | First | Middle | Last | 4. DATE OF DEATH | Month | Day | Year | |
| | | Salvatora | | Decormelo | 9 | 9 | 30 | 19 60 | |
| 5. SEX | 6. COLOR OR RACE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. IF UNDER 1 YEAR | 11. IF UNDER 24 HRS | | |
| female | white | WIDOWED <input type="checkbox"/> | DIVORCED <input type="checkbox"/> | 1866? | 94? yrs | Months | Days | Hours | Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| Laundress | | Laundry | | Sicily | | USA | | | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | | | |
| ? Unknown | | | | ? Unknown | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | | |
| | | | | Springfield State Hospital records | | Sykesville, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) | | Chronic degenerative myocarditis | | | | years | | | |
| 422 Conditions if any, which gave rise to immediate cause (a), stating the under- lying cause first. | | | | | | | | | |
| DUE TO (b) | | Arteriosclerotic cardio-vascular disease | | | | years | | | |
| DUE TO (c) | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| Schizophrenic Reaction, Catatonic Type. | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Hour o. m. p. m. | | 20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) | (State) | |
| 19 | | | | | | | | | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 12/31 1960 to 9/30 1960, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 9/30/1960, and that death occurred at 9:50 AM, from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE | | M D | | ATTENDING PHYS <input type="checkbox"/> | MED DIRECTOR <input type="checkbox"/> | STAFF PHYS <input checked="" type="checkbox"/> | 22b. DATE SIGNED | | |
| Konstantin Weber | | | | | | | 9/30/60 | | |
| 22c. PHYSICIAN'S NAME (Type) | | 22d. ADDRESS | | Springfield State Hospital | | | | | |
| Konstantin Weber, M. D. | | Sykesville, Maryland | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Spcl Fy) | | 23b. DATE THEREOF | | 23c. NAME OF CEMETERY OR CREMATORI | | 23d. LOCAT ON (City, town, or county) | | (State) | |
| 10/1/60 | | | | Freedom | | Edensburg, Carroll Co., Md. | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| F. H. Haight, Sykesville, Md. | | | | OCT 4 '60 | | Ollie S. Haight | | | |

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 515071 9-19-60 et

10113

10145

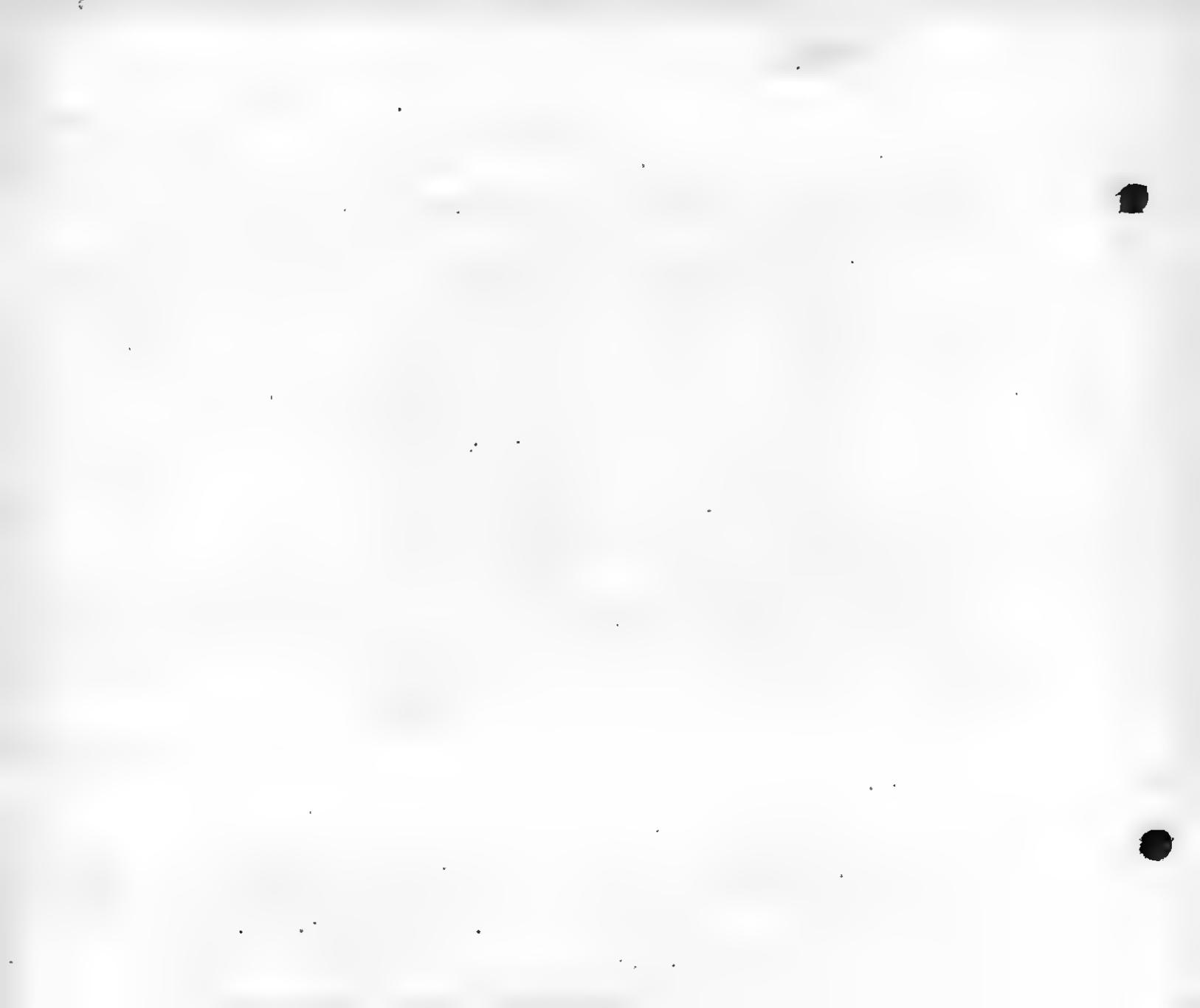
CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | | | | | |
|--|------------------|--|----------------|--|------------------|---|--|------------------------------|--|---------------------------------------|-------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Carroll | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland | | b. COUNTY Baltimore | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville | | c. LENGTH OF STAY IN 1b 2 yr. 1 mon 17 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Nowson/ Baltimore 16 | | 3. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital | | d. STREET ADDRESS 3207 Clifton Avenue Nowson/ Conn. / Home | | 4. DATE OF DEATH 9 | | Month 10 | Day 19 | Year 60 | | | |
| 3. NAME OF DECEASED (Type or print) | First Cecelia | Middle Margaret | Last Dumler | Lost | 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH 11-16-77 | 9. AGE (In years lost birthday) 82 yrs. | 10. IF UNDER 1 YEAR Months Days | 11. IF UNDER 24 HRS Hours Min |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-wife | | 10b. KIND OF BUSINESS OR INDUSTRY none | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12 CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | |
| 13. FATHER'S NAME Leopold Wieman | | 14. MOTHER'S MAIDEN NAME Margaretha Jurgens | | 15. INFORMANT Hospital records | | Address | | | | | |
| 16. SOCIAL SECURITY NO no | | 17. DUE TO PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420-0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost (b) Arteriosclerotic heart disease (c) | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] Coronary arteriosclerosis Arteriosclerotic heart disease | | 19. INTERVAL BETWEEN ONSET AND DEATH years | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic Brain Syndrome assoc. with arteriosclerosis | | 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | | | 20g. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21. I certify that I attended the deceased from July 24, 1958, to Sept. 10, 1960 that I last saw the deceased alive on Sept. 10, 1960, and that death occurred at 9:05 P.M. from the causes and on the date stated above. | | ACTUAL SIGNATURE Dr. Ilse Kamm | | M.D. | | ADDRESS (Street, city or town, state) Sykesville, Maryland | | | DATE SIGNED 9-11-60 | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 9/14/60 | | 22c. NAME OF CEMETERY OR CREMATORIAL New Cathedral Cem. | | 22d. LOCATION (City, town, or county) Balto., Md. | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE John J. Schaefer & Sons - Balto. | | ADDRESS 17 Med | | 24a. REC'D BY REGISTRAR DATE SEP 13 '60 | | 24b. REGISTRAR'S SIGNATURE Cecilia S. Thomas | | | | | |



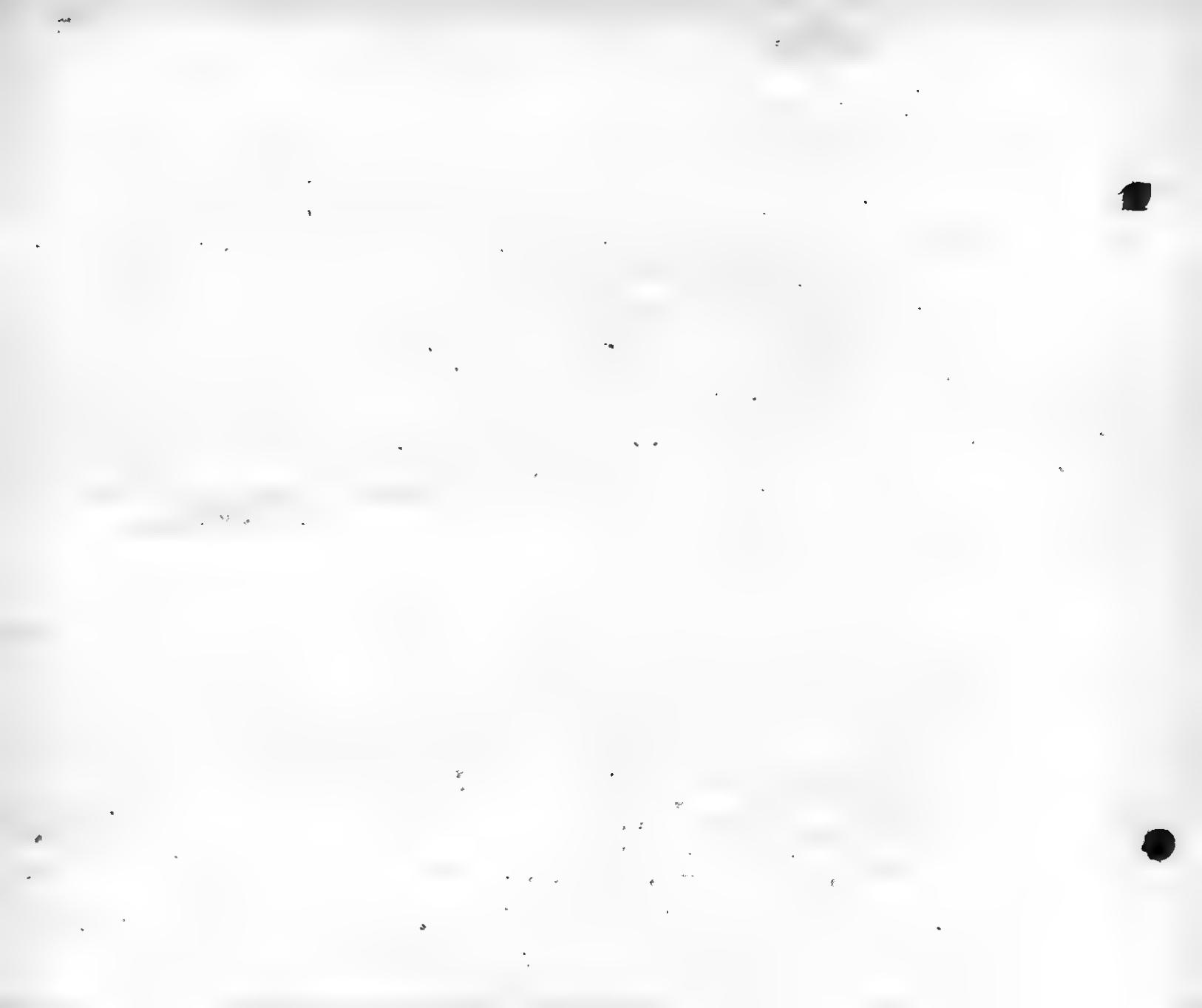
10114

10132

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | |
|---|--|---|--|---|---|
| 1 PLACE OF DEATH a. COUNTY <i>Carroll</i> | | MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Westminster</i> | | c. LENGTH OF STAY IN 1b <i>5 days</i> | | d. STATE <i>Md.</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>35 First St.</i> | | e. STREET ADDRESS <i>35 First St.</i> | | f. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Westminster</i> | |
| 3. NAME OF DECEASED (Type or print) <i>DAVID HOWARD ECKARD</i> | | First | Middle | Last | 4. DATE OF DEATH <i>SEPT. 19 1960</i> |
| 5. SEX <i>Male</i> | | 6. COLOR OR RACE <i>White</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <i>Never married</i> | 8. DATE OF BIRTH <i>May 18, 1878</i> | 9. AGE (In years last birthday) <i>82 yrs</i> |
| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Senator, Church and Movie</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Carroll Co. 721. 454.</i> | | 11. BIRTHPLACE (State or foreign country) <i>Carroll Co. Md.</i> | |
| 13. FATHER'S NAME <i>Henry Eckard</i> | | 14. MOTHER'S MAIDEN NAME <i>Sarah Wilkins</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>S. Author</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> | | 16. SOCIAL SECURITY NO <i>28-147247</i> | | INFORMANT <i>Dr. Howard Eckard, deceased, 45 First St.</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | INTERVAL BETWEEN ONSET AND DEATH <i>4 yrs</i> | | | |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>450.0</i> | | DUE TO <i>Generalized arterio-sclerotic</i> | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>(b)</i> | | DUE TO <i>(c)</i> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>15 Remper Ave.</i> (City or town) <i>Westminster</i> (County) <i>Md.</i> (State) <i>Md.</i> | |
| 21. I certify that I attended the deceased from <i>Sept 19 60</i> to <i>Sept 19 60</i> at <i>Westminster</i> , Md. that I last saw the deceased alive on <i>Sept 19 60</i> and that death occurred at <i>7:45 P.M.</i> from the causes and on the date stated above | | | | | |
| ADDRESS (Street, city or town, state) <i>15 Remper Ave. Westminster Md.</i> DATE SIGNED <i>9/20/60</i> | | | | | |
| ACTUAL SIGNATURE <i>C. Reese Wilkins M.D.</i> | | PHYSICIAN'S NAME (Type) <i>C. REESE WILKENS</i> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 22b. DATE THEREOF <i>9/22/60</i> | | 22c. NAME OF CEMETERY OR CREMATORIAL <i>Widener Cemetery</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>C. Reese Wilkins, M.D.</i> | | ADDRESS <i>118 Remper Ave. Westminster Md.</i> | | 22d. LOCATION (City, town, or county) <i>Westminster</i> (State) <i>Md.</i> | |
| 24a. REC'D. BY REGISTRAR <i>John S. Knapp</i> | | 24b. REGISTRAR'S SIGNATURE <i>John S. Knapp</i> | | | |
| DATE <i>SEP 21 '60</i> | | | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

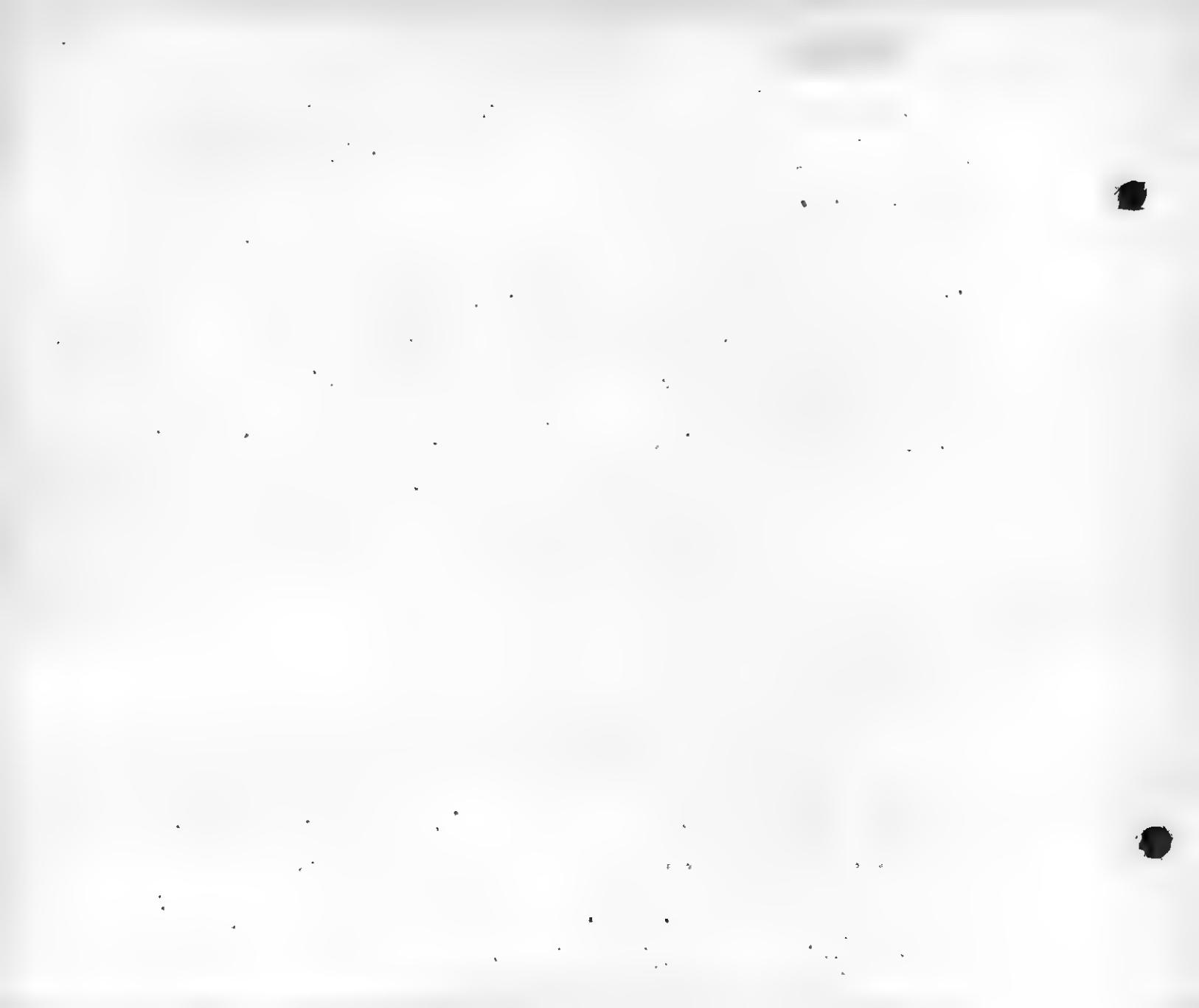
Item 2 FILE # 10129-19-60 et

10115

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY <i>Carroll</i> | | 2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <i>Maryland</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Manchester</i> | | c. LENGTH OF STAY IN 1b <i>5 yrs</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Longmeadow Home</i> | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hampstead</i> | |
| 3. NAME OF DECEASED (Type or print) <i>JOHN H. EHRHART</i> | | First <i>J</i> | Middle <i>H</i> |
| 4. DATE OF DEATH <i>Sept 10 1960</i> | | Last <i></i> | Month <i></i> |
| 5. SEX <i>M</i> | | 6. COLOR OR RACE <i>W</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 8. DATE OF BIRTH <i>Oct 28-1874</i> | | 9. AGE (In years last birthday) <i>85 yrs</i> | 10. IF UNDER 1 YEAR Months <i></i> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Harnet</i> | 10c. BIRTHPLACE (State or foreign country) <i>Maryland</i> |
| 11. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i> | | 12. MOTHER'S MAIDEN NAME <i>Annie Dickmeyer</i> | |
| 13. FATHER'S NAME <i>George Ehrhart</i> | | 14. INFORMANT <i>John Ehrhart - Hampstead Md</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>110-110-110</i> | |
| 17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>443X</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i> | |
| DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c) | | Congestive Heart Failure Hypertensive C.V. Disease 20 yrs. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 18. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i> | | 20b. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/> | 20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20d. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <i>June 1954</i> to <i>Sept. 10 1960</i> that I last saw the deceased alive on <i>Sept. 9 1960</i> , and that death occurred at <i>9:30 a.m.</i> from the causes and on the date stated above | | ADDRESS (Street, city or town, state) <i>Hampstead, Md.</i> | |
| ACTUAL SIGNATURE <i>M. C. Porterfield</i> | | DATE SIGNED <i>9-10-60</i> | |
| PHYSICIAN'S NAME (Type) <i>M. C. Porterfield, M.D.</i> | | 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | |
| 22b. DATE THEREOF <i>9-13-1960</i> | | 22c. NAME OF CEMETERY OR CREMATORIAL <i>St. Mary's Cemetery</i> | |
| 22d. LOCATION (City, town, or county) <i>Baltimore Co. Maryland</i> | | 23. FUNERAL DIRECTOR'S SIGNATURE <i>Edie & Gipton Hampstead Md</i> | |
| 24a. REC'D BY REGISTRAR DATE <i>SEP 14 1960</i> | | 24b. REGISTRAR'S SIGNATURE <i>John S. Kline</i> | |



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be reh by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10116

| | | | |
|--|--|---|--|
| 1 PLACE OF DEATH a. COUNTY | | 2 USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE | |
| Carroll | | MARYLAND Maryland Carroll | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. LENGTH OF STAY IN 1b 3 weeks | |
| Westminster Rural | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster Rural RD #4 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS Houck Road | |
| Houck Road | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print) | | First | Middle |
| Maude | | A. | Finster |
| 4. DATE OF DEATH | | Month | Day |
| September 15 | | Year | 1960 |
| 5. SEX | | 6. COLOR OR RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |
| Female | | white | Mar 12-1883 77 yrs. |
| 8. DATE OF BIRTH | | 9. AGE (In years last birthday) | 10. IF UNDER 1 YEAR Months Days Hours Min |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) |
| House wife | | Home | Maryland |
| 12. CITIZEN OF WHAT COUNTRY? | | U.S.A. | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | |
| Beaumont Franklin Brumwell | | Eugene Bushman | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT |
| no. | | none | Mrs. Harriett Zepo |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | Address | |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) | | INTERVAL BETWEEN ONSET AND DEATH | |
| +22 Chronic Myocarditis | | ? | |
| Conditions if any, which gave rise to immediate cause (a), stating the under- lying cause last. | | DUE TO | |
| { | | (b) Arteriosclerotic Cardi Vascula Disease. ? | |
| DUE TO | | (c) | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour a. m. p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |
| 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from May 24, 1960, to September 15, 1960, that (I) (we) last saw the deceased alive on Sept 14, 1960, and that death occurred at 7 A.M. from the causes and on the date stated above. | | 22b. DATE SIGNED 9/15/60 | |
| 22a. SIGNATURE Joseph E. Bush MD | | M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | 22d. ADDRESS Hampstead Maryland |
| 22c. PHYSICIAN'S NAME (Type) Joseph E. Bush MD | | 23a. RURAL, CREMATION, REMOVAL (Specify) | |
| 23b. DATE THEREOF 9-17-1960 | | 23c. NAME OF CEMETERY OR CREMATORIAL Towle | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Edw E Tipton Hampstead Md | | 25a. REC'D BY REGISTRAR DATE SEP 19 '60 | |
| 25b. REGISTRAR'S SIGNATURE Arthur S. Kress | | | |



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10147

CERTIFICATE OF DEATH

10117

Item 8 Film 6272

| | | | | | |
|---|--|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY | | Carroll County MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived - If institution- Residence before admission) | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. LENGTH OF STAY IN 1b 47 years 3 mos. 25 days | | a. STATE Maryland b. COUNTY Baltimore City | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | Springfield State Hospital | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | |
| 3. NAME OF DECEASED (Type or print) | | First Rosie | Middle Agnes | Last McCall | 4. DATE OF DEATH September 26 Month Year 1960 |
| 5. SEX Female | | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 11/14/ 1877 1876 | 9. AGE (In years last birthday) 83 yrs. | 10. IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY At Home | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | |
| 13. FATHER'S NAME J. Hugh McCall | | 14. MOTHER'S MAIDEN NAME Sarah | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO ----- | | 17. INFORMANT Springfield Hospital Records, Sykesville, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.0 | | DUE TO | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. | | (b) Arterial Schlerotic Heart Disease years | | | |
| DUE TO | | (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION IN PART I(a) Schizophrenic reaction, paranoid type. | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from May 31, 1960, to September 26, 1960, that (I) (we) last saw the deceased alive on 9-26-1960, and that death occurred at 10:10 A.M. from the causes and on the date stated above | | 22b. DATE 9-26-60 SIGNED | | | |
| 22a. SIGNATURE Agustin del Campo, M.D. | | 22b. ADDRESS Springfield State Hospital, Sykesville, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 9/29/60 | | 23c. NAME OF CEMETERY OR CREMATORIAL Baltimore National | |
| 24. FUNERAL DIRECTOR'S SIGNATURE C. Vernon Lammens | | ADDRESS 4611 Park Heights, Balto. Md. | | 25a. REC'D BY REGISTRAR DATE SEP 28 '60 | |
| VR A15 (4) 1SM 9/59 | | 25b. REGISTRAR'S SIGNATURE Cecilia S. Kraus | | | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10148

10118

Reg. Dist. No.

| | | | | | | | | |
|---|---|--|---|---|--|--|---|------------------------------|
| 1. PLACE OF DEATH a. COUNTY Carroll MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville | | c. LENGTH OF STAY IN lb 9mos.11 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clear Spring --Indian Springs | | d. STREET ADDRESS Big Pool RFD #1 | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) Leonard | | First Leonard | Middle Dallas | Last Forsythe | 4. DATE OF DEATH September 13, 1960 | Month | Doy | Year |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | Sept. 3, 1881 | 9. AGE (in years last birthday) 79 yrs. | 10. IF UNDER 1 YEAR Months 0 Days 9 | 11. IF UNDER 24 HRS Hours 0 Min. 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown | | 10b. KIND OF BUSINESS OR INDUSTRY - | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME David Forsythe | | | | 14. MOTHER'S MAIDEN NAME Susan Murray | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. No | | 17. INFORMANT Springfield Hospital Records. | | Address | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Exhaustion due to exposure INTERVAL BETWEEN ONSET AND DEATH Days. | | | | | | | | |
| DUE TO Conditions, if any, which gave rise to immediate (a), stating the underlying cause last. (b) Arteriosclerotic heart disease Years. | | | | | | | | |
| DUE TO (c) Coronary arteriosclerosis Years. | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with senile brain disease with psychotic reaction. | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Shanktown E. Sub Cem. | | 20f. (City or town) Shanktown | | (County) Md. | (State) Md. |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> | | | | | | | | |
| ACTUAL SIGNATURE <i>James T. Marsh</i> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | | | DATE SIGNED 9/13/60 | |
| EXAMINER'S NAME (Type) James T. Marsh, M.D. | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Sept. 16-60 | | 22c. NAME OF CEMETERY OR CREMATORIUM Shanktown E. Sub Cem. | | 22d. LOCATION (City, town, or county) Shanktown | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Albert L. Lead</i> | | ADDRESS <i>311 Leoma Dr. #1</i> | | 24a. REC'D BY REGISTRAR SEP 19 '60 | | 24b. REGISTRAR'S SIGNATURE <i>Arthur J. Moore</i> | | |
| VS. A15ME(5) 5M 9/55 | | | | | | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10149

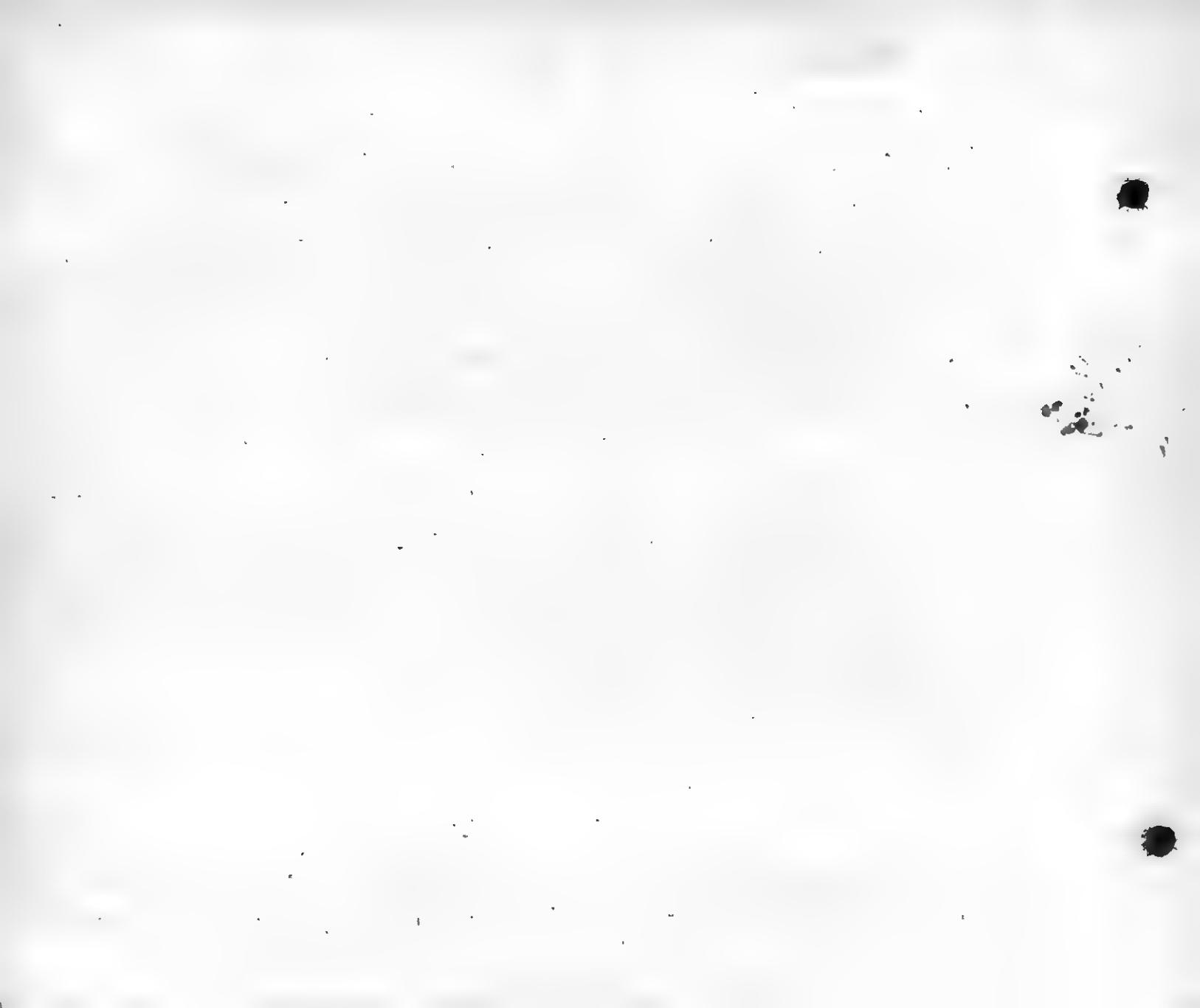
CERTIFICATE OF DEATH

10119

Reg. Dist. No.

TO HOSPITAL: may be referred by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY <i>CARROLL</i> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>UNION BRIDGE</i> | | c. LENGTH OF STAY IN 1b <i>YEARS</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>WHYTE ST.</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>UNION BRIDGE</i> | |
| d. STREET ADDRESS <i>WHYTE ST.</i> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <i>EDWARD DAVID FURRY</i> | | First <i>EDWARD</i> | Middle <i>DAVID</i> |
| 3. NAME OF DECEASED (Type or print) <i>EDWARD DAVID FURRY</i> | | Last <i>FURRY</i> | 4. DATE OF DEATH <i>SEPT. 20 1960</i> |
| 5. SEX <i>MALE</i> | 6. COLOR OR RACE <i>WHITE</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B. DATE OF BIRTH <i>WIDOWED</i> <input checked="" type="checkbox"/> DIVORCED <i>JULY 27-1873</i> | 9. AGE (In years lost birthday) yrs. <i>87</i> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>MERCHANT-FARMER- RETIRED</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>MARYLAND</i> | |
| 10c. BIRTHPLACE (State or foreign country) <i>MARYLAND</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i> | |
| 13. FATHER'S NAME <i>SAMUEL B. FURRY</i> | | 14. MOTHER'S MAIDEN NAME <i>ELIZABETH MYERS</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> | | 16. SOCIAL SECURITY NO <i>216-22-9328</i> | |
| 17. PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE <i>Acute Cardiac Nivation</i> | | 18. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>161X</i> | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)</i> | |
| 20c. TIME OF INJURY Hour o. m. p. m. <i>19</i> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>20f. (City or town) (County) (State)</i> | | 20f. (City or town) <i>UNION BRIDGE</i> | |
| 21. I certify that I attended the deceased from <i>6-19 1960</i> to <i>9-20-1960</i> that I last saw the deceased alive on <i>9-18 1960</i> , and that death occurred at <i>UNION BRIDGE MD</i> from the causes and on the date stated above. | | 22. ADDRESS (Street, city or town, state) <i>UNION BRIDGE MD</i> | |
| 23. ACTUAL SIGNATURE <i>J. H. LOGG M.D.</i> | | 24. DATE SIGNED <i>9-20-60</i> | |
| 25. PHYSICIAN'S NAME (Type) <i>J. H. LOGG MD</i> | | 26. BURIAL, CREMATION REMOVAL (Specify) <i>BURIAL</i> | |
| 27. FUNERAL DIRECTOR'S SIGNATURE <i>D. Hartfus & Sons UNION BRIDGE MD</i> | | 28. DATE THEREOF <i>9/23/60</i> | |
| 29. NAME OF CEMETERY OR CREMATORIUM <i>BEAVER DAM CEM.</i> | | 30. LOCATION (City, town, or county) <i>FREDERICK COUNTY MD</i> | |
| 31. ADDRESS <i>UNION BRIDGE MD</i> | | 32. REC'D BY REGISTRAR <i>Arthur S. Knau</i> | |
| 33. REGISTRAR'S SIGNATURE <i>Arthur S. Knau</i> | | 34. DATE SEP 23 '60 | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10133

CERTIFICATE OF DEATH

Reg. Dist. No.

10120

| | | | | | | | |
|---|--|--|---|--|--------------------------------------|--|---------------------|
| 1. PLACE OF DEATH a. COUNTY CARROLL | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND | | b. COUNTY CARROLL | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER - | | c. LENGTH OF STAY IN 1b 15 YRS | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER | | d. STREET ADDRESS 123 PENNSYLVANIA AVE. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION — | | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | First LEVI | Middle ELMER | Last GAMBER | 4. DATE OF DEATH | Month SEPT. | Day 13 | Year 1960 |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9/23/1872 | 8. AGE (In years last birthday) 87 yrs. | 9. IF UNDER 1 YEAR Months 0 | | IF UNDER 24 HRS. Hours 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BARBER | | 10b. KIND OF BUSINESS OR INDUSTRY BARBER - | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME WILLIAM GAMBER | | 14. MOTHER'S MAIDEN NAME MARIA | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. NO NO | | 17. INFORMANT EDWARD BAILEY - WESTMINSTER, MD. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c) | | Heart failure | | | | INTERVAL BETWEEN ONSET AND DEATH 6 days | |
| | | Myocardial degeneration | | | | 3+ mos | |
| | | Arteriosclerosis | | | | 2+ yrs. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Asthma | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18] — | | | | | |
| 20c. TIME OF INJURY | Month, Day, Year Hour o. m. p. m. | 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) M.D. | 20f. (City or town) 15 Kenner Ave | (County) | (State) |
| 21. I certify that I attended the deceased from Jan 21 , 19 60 , to Sept 13 , 19 60 , that I last saw the deceased alive on Sept 13 , 19 60 , and that death occurred at 11:30 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE E. REESE WILKENS FIRM/INSTITUTION NAME (Type) E. REESE WILKENS ADDRESS (Street, city or town, state) 15 Kenner Ave DATE SIGNED 9/14/60 Sept 13, 1960 | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 22b. DATE THEREOF 9/16/60 | 22c. NAME OF CEMETERY OR CREMATORIAL PROVIDENCE | 22d. LOCATION (City, town, or county) GAMBER, MD. | | | (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE James G. Saffell | | ADDRESS Westminster, MD. | 24a. REC'D BY REGISTRAR DATE SEP 16 '60 | 24b. REGISTRAR'S SIGNATURE James G. Saffell | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10150

CERTIFICATE OF DEATH

Reg. Dist. No.

10121

| | | | | | | | | | |
|---|--|---|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY CHARROLL | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) NEW WINDSOR | | c. LENGTH OF STAY IN lb YEARS | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND | | b. COUNTY CARROLL | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEDFORD | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ALB. WINDSOR | | f. STREET ADDRESS MEDFORD | | g. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ALB. WINDSOR | | h. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) CHARLES | | First GEORGE | | Middle GRAHAM | | 4. DATE OF DEATH Month SEPT Day 24 Year 1960 | | | |
| 5. SEX M | | 6. COLOR OR RACE W | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH FEB 21, 1899 | | 9. AGE (In years last birthday) 61 yrs | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WAREHOUSE - SHOE | | 10b. KIND OF BUSINESS OR INDUSTRY MFG. | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? USA | | | |
| 13. FATHER'S NAME HARRY GRAHAM | | 14. MOTHER'S M AIDEN NAME SOPHIA HESS | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO | | 16. SOCIAL SECURITY NO 013-05-1254 | | 17. INFORMANT IRENE GRAHAM NEW WINDSOR MD | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ca of Prostate with metastasis | | DUE TO | | | | INTERVAL BETWEEN ONSET AND DEATH 15 mo. | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) | | DUE TO | | | | | | | |
| (c) | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) ALB. WINDSOR (County) MD (State) MD | | | |
| 21. I certify that I attended the deceased from Dec 24, 1958 to 9-23-1960 , that I last saw the deceased alive on 9-23-1960 , and that death occurred at 2 AM , from the causes and on the date stated above. | | | | | | | | ADDRESS (Street, city or town, state) ALB. WINDSOR MD | |
| ACTUAL SIGNATURE James T. Marsh | | M.D. | | | | | | DATE SIGNED 9-26-60 | |
| PHYSICIAN'S NAME (Type) JAMES T. MARSH | | | | | | | | | |
| 22e. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 9/27/60 | | 22c. NAME OF CEMETERY OR CREMATORIAL PIPE CREEK | | 22d. LOCATION (City, town, or county) CARROLL Co MD | | (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Dr Hartman, New Windsor | | ADDRESS | | | | 24a. REC'D BY REGISTRAR DAE SEP 28 '60 | | 24b. REGISTRAR'S SIGNATURE Charles S. Hunt | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be relied on by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL The law requires that the death certificate be executed within 24 hours after death
 may be rec'd by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

115

1

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item 9 filled in by doctor

10151 **10122**

| | | | |
|---|-------------------------------|--|-------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Carroll | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville, | | c. LENGTH OF STAY IN lb 4 yrs. I mot. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Mary (May) | First | Middle Ellen | Last Hall |
| 4. DATE OF DEATH 9 3 1960 | Month | Day | Year |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH II/23/90 |
| 9. AGE (In years last birthday) 70 69 yr | 10. IF UNDER 1 YEAR Months | 11. IF UNDER 24 HRS Days | 12. IF UNDER 24 HRS Hours |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper | | 10b. KIND OF BUSINESS OR INDUSTRY U.S.A. (Baltimore) | |
| 13. FATHER'S NAME Frank Osborn | | 14. MOTHER'S MAIDEN NAME Margaret Hodges | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO 215-32-0410 | |
| 17. INFORMANT Springfield State Hospital, Sykesville, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | INTERVAL BETWEEN ONSET AND DEATH Days | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-Pneumonia | | | |
| DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. Arterio-sclerotic Cardio-Vascular Disease | | Months | |
| DUE TO (b) DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Involutional Psychotic Reaction | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18) | |
| 20c. TIME OF INJURY Hour o. m p. m 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 9/3/1960 , to 9/3/1960 , that (I) (we) last saw the deceased alive on 9/3/1960 , and that death occurred at 12:55 M, from the causes and on the date stated above. | | 22b. DATE SIGNED 9-3-60 | |
| 22c. PHYSICIAN'S NAME (Type) Agustin del Campo | | 22d. ADDRESS Springfield State Hospital | |
| 23a. BURIAL, CREMATION (City) BURIED | | 23b. DATE THEREOF 9-6-60 | |
| 23c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet Cemetery | | 23d. LOCATION (City, town, or county) Baltimore | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street | | 25a. REC'D BY REGISTRAR DATE SEP 8 '60 | |
| | | 25b. REGISTRAR'S SIGNATURE Charles S. Moore | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10152

CERTIFICATE OF DEATH

Reg. Dist. No. 10123

TO HOSPITAL: by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | | |
|--|---------------------------|---|--|---|---|---|-----------------------------------|--------------|
| 1. PLACE OF DEATH a. COUNTY Carroll | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland | | b. COUNTY Carroll | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodbine | | c. LENGTH OF STAY IN lb | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Woodbine | | d. STREET ADDRESS Box 14 | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box 14 | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) | | First Ira | Middle Owens | Last Harrison | 4. DATE OF DEATH Sept. 5 1960 | Month Sept. | Day 5 | Year 1960 |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | Aug. 7, 1893 | 9. AGE (In years last birthday) 67 yrs. | 10. IF UNDER 1 YEAR Months 0 | 11. IF UNDER 24 HRS. Days 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Florence, Md. | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME Nimrod Harrison | | 14. MOTHER'S MAIDEN NAME Janie Sullivan | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 215-20-9920 | | INFORMANT Mrs Mamie E. Harrison, Woodbine, Md. | | Address | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) | | DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. | | Central Hemorrhage, Complete paralysis, Arteriosclerosis Generalized, arteriosclerotic heart dis. | | INTERVAL BETWEEN ONSET AND DEATH 1955 to 5 Sept 60 | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | | | | |
| 20c. TIME OF INJURY Hour o. m. p. m. | | Month 19 | Doy 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) Florence, Md. | (County) (State) | |
| 21. I certify that I attended the deceased from 1955, 19, to 5 Sept, 1960, that I last saw the deceased alive on 5 Sept, 1960, and that death occurred at 8:30 P.M. from the causes and on the date stated above. | | | | ADDRESS (Street, city or town, state) Howard E. Hall, M.D., Woodbine, Md. | | DATE SIGNED 6 Sept 60 | | |
| ACTUAL SIGNATURE Howard E. Hall, M.D. | | | | | | | | |
| PHYSICIAN'S NAME (Type) Howard E. Hall | | | | | | | | |
| 22a. BURIAL/CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 9/8/60 | | 22c. NAME OF CEMETERY OR CREMATORIAL Jennings Chapel | | 22d. LOCATION (City, town, or county) Florence, Md. (State) | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Olin L. Moharonth | | ADDRESS Damascus, Md. | | 24a. REC'D BY REGISTRAR DATE SEP 8 '60 | | 24b. REGISTRAR'S SIGNATURE Olin L. Moharonth | | |



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10124

CERTIFICATE OF DEATH

10124

| | | | | | | | | |
|---|--|---|--|--|--|---|-----------------------------|---|
| 1. PLACE OF DEATH a. COUNTY Carroll | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland | | b. COUNTY | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville | | c. LENGTH OF STAY IN 1b 18 years | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | | d. STREET ADDRESS 318 Norris Street | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital | | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) Catherine | | First | Middle | Last | 4. DATE OF DEATH Hartman | Month | Day | Year |
| 5. SEX Female | | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 2-8-91 | 9. AGE (In years lost birthday) 69 yrs | 10. IF UNDER 1 YEAR Months | 11. IF UNDER 24 HRS Days | Hours |
| 10a. USJA. OCCUPATION (Give kind of work done during most of working life, even if retired) Hand Ironer | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Balto. Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME Joseph Bander | | 14. MOTHER'S MAIDEN NAME Mary Ward | | Address Dolores Johnson-626 Scott Street | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO (If yes, give war or dates of service) | | 17. INFORMANT | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Advanced Pulmonary TBC | | |
| DUE TO 002X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. | | DUE TO ASCVD | | DUE TO Diabetes Mellitus | | INTERVAL BETWEEN ONSET AND DEATH | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20d. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19 | | 20b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 8-31 8-42 to 9-11 | | (County) (State) |
| 20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. | | 20f. (City or town) | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 9-11-60 to 9-11-60 , that (I) (we) last saw the deceased alive on 9-11-60 , and that death occurred at 5:55 PM , from the causes and on the date stated above | | 22d. SIGNATURE Agustin del Campo | | ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> | | 22d. SIGNATURE Agustin del Campo | | 22d. ADDRESS Springfield State Hospital |
| 22c. PHYSICIAN'S NAME (Type) Agustin del Campo | | 23c. NAME OF CEMETERY OR CREMATORIUM Baltimore Cem. | | 23d. LOCATION (City, town, or county) Balto. Md. | | (State) | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 9-13-60 | | 23e. ADDRESS Springfield State Hospital | | 25a. RECEIVED BY REGISTRAR SEP 14 '60 | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Kraus | | 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus | | DATE | | | | |

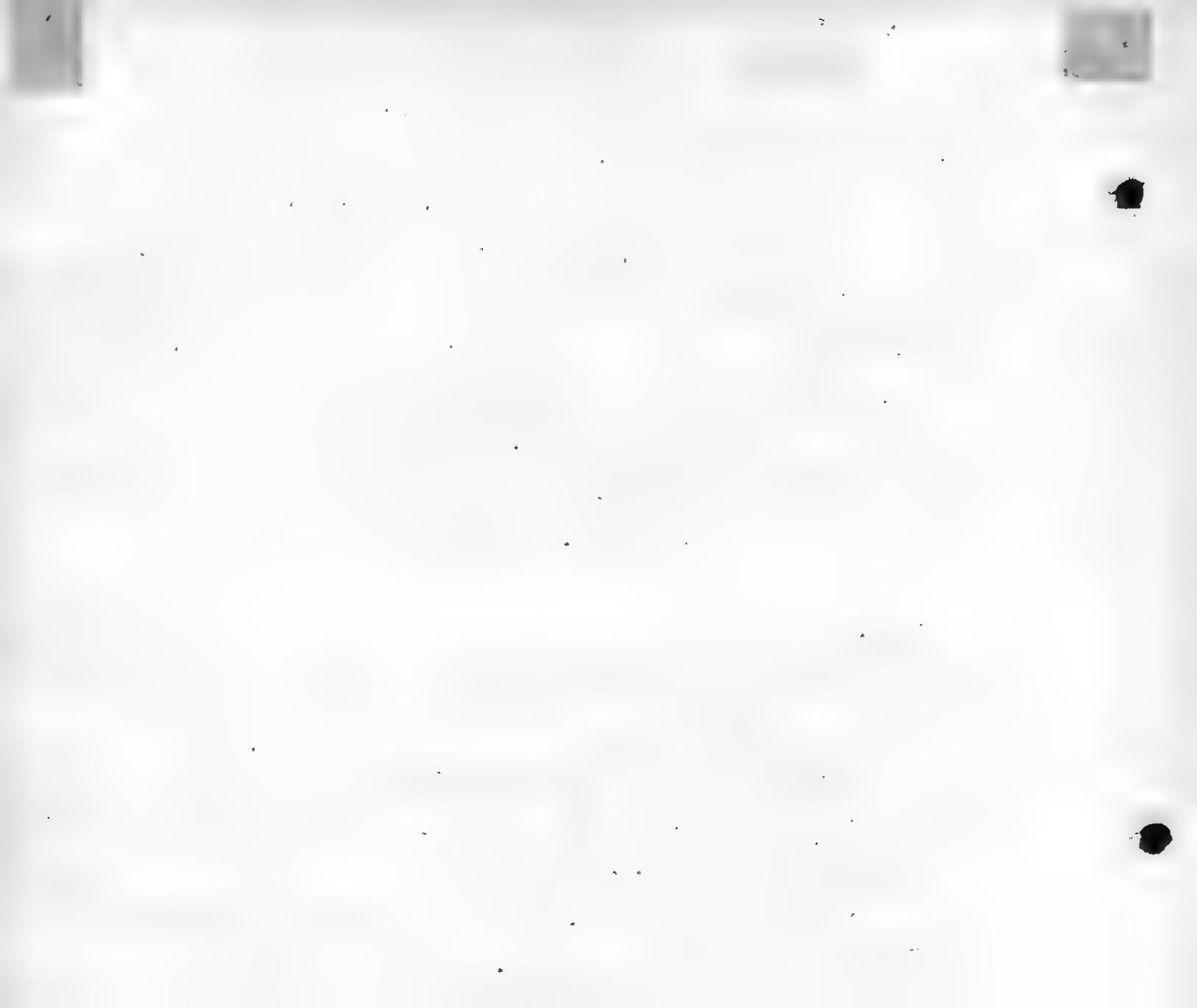


MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 10125

| | | | | | | | |
|---|----------------------------------|--|--------------------------------------|--|---------------------------------------|--|---------------------|
| 1. PLACE OF DEATH a. COUNTY Carroll | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland | | b. COUNTY Washington | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville | | c. LENGTH OF STAY IN lb 29yr. 9mo. 28days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown | | d. STREET ADDRESS 410 McDowell Avenue | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) Mabel | First V. | Middle HAESNBUHLER | Last | 4. DATE OF DEATH SEPTEMBER 20 1960 | Month SEPTEMBER | Day 20 | Year 1960 |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | B. DATE OF BIRTH 9-16-1886 | 9. AGE (In years last birthday) 74 yrs | IF UNDER 1 YEAR Months 7 | IF UNDER 24 HRS Days 14 | Hours 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Ohio | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME William E. Butts | | | | 14. MOTHER'S MAIDEN NAME Annie Smith | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. | | INFORMANT Hospital Records | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion | | | | | | | |
| DUE TO 420.1 | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular Disease | | | | | | | |
| DUE TO (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Epilepsy. | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH Minutes | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 9/7/60 , 19 60 , to 9-20 , 19 60 , that I last saw the deceased alive on September 20, 1960 , and that death occurred at 10:15 PM , from the causes and on the date stated above. | | | | | | | |
| ADDRESS (Street, city or town, state) | | | | | | | |
| DATE SIGNED 9-21-60 | | | | | | | |
| ACTUAL SIGNATURE <i>J. Raymond Gladue</i> | | M.D. Springfield State Hospital | | | | | |
| PHYSICIAN'S NAME (Type) J. Raymond Gladue, M.D. | | Sykesville, Maryland | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 9/23/1960 | | 22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery | | 22d. LOCATION (City, town, or county) Hagerstown, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Suter | | ADDRESS Funeral Home | | 24a. REC'D BY REGISTRAR George Long | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kimes | |
| | | | | DATE SEP 23 '60 | | | |



TO HOSPITAL by the hospital or attending physician. **TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

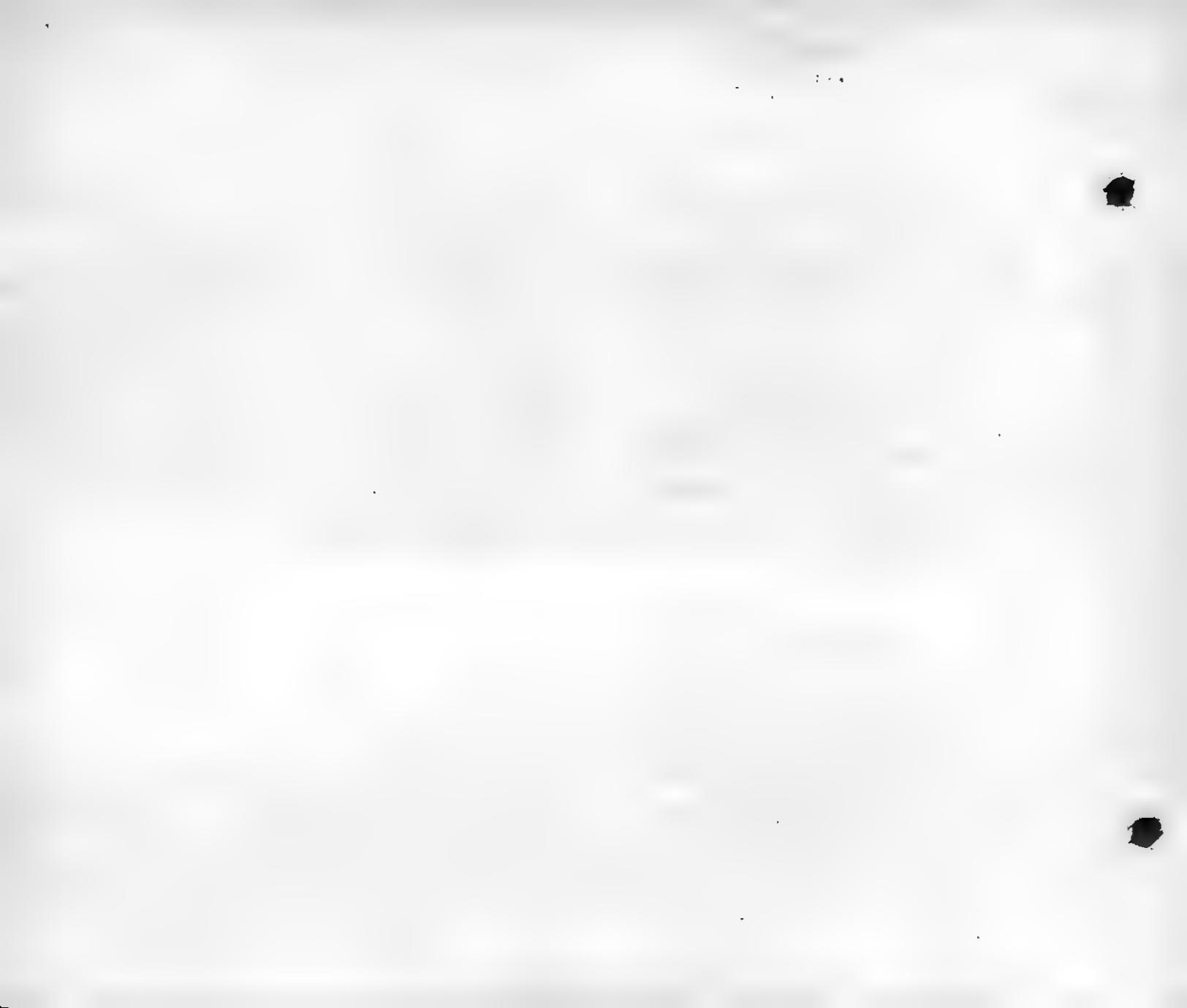
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10135

CERTIFICATE OF DEATH

10126

| | | | | | | | |
|---|------------------|---|--|---|---|---|----------------------------------|
| 1. PLACE OF DEATH a. COUNTY | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. LENGTH OF STAY IN 1b 13 days | | 2. USUAL RESIDENCE (Where deceased lived if institution residence before admission) a. STATE | |
| Carroll | | Maryland | | Maryland | | b. COUNTY | |
| | | | | Somerset | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield | | 1939-2 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| Henryton State Hospital | | 16 S. 4th Street | | | | | |
| 3. NAME OF DECEASED (Type or print) | | First | Middle | 4. DATE OF DEATH | Month | Day | Year |
| | | Annie | | Hearn | September | 27 | 1960 |
| S. SEX | 6. COLOR OR RACE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years last birthday) 75 yrs | 10. IF UNDER 1 YEAR Months | 11. IF UNDER 24 HRS Hours Min |
| Female | Negro | | | 2-15-1887 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Crisfield, Md. | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Washington Miles | | 14. MOTHER'S MAIDEN NAME Annie Ward | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO None | | 17. INFORMANT Annie Hearn-Patient | | Address | |
| No | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | Cardiovascular insufficiency. Pneumonitis | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| COPD | | DUE TO (b) Far advanced bilateral pulmonary TB | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. | | DUE TO (c) | | | | | |
| Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | | | |
| 20c. TIME OF INJURY Hour a. m. p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 19 | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from September 14, 60, to September 27, 60, that (I) (we) last saw the deceased alive on Sept. 27, 1960, and that death occurred at 1:55A, from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Edgars M. Maculans | | M.D. | | ATTENDING PHYS. <input type="checkbox"/> | MED. DIRECTOR <input checked="" type="checkbox"/> | STAFF PHYS <input type="checkbox"/> | 22b. DATE SIGNED 9-27-60 |
| 22c. PHYSICIAN'S NAME (Type) Edgars M. Maculans | | | | 22d. ADDRESS Henryton State Hospital, Henryton, Md. | | | |
| 23a. BURIAL, CREMATION OR REMOVAL (Specify) Burial | | 23b. DATE THEREOF Oct 2, 1960 | | 23c. NAME OF CEMETERY OR CREMATORIUM Asbury Cemetery | | 23d. LOCATION (City, town, or county) Som. Blot | |
| | | | | | | Tansboro, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Anthony E. Ward | | ADDRESS 108 34 1/2 St Crisfield | | 25a. REC'D BY REGISTRAR DATE SEP 30 '60 | | 25b. REGISTRAR'S SIGNATURE Arthur S. Kline | |



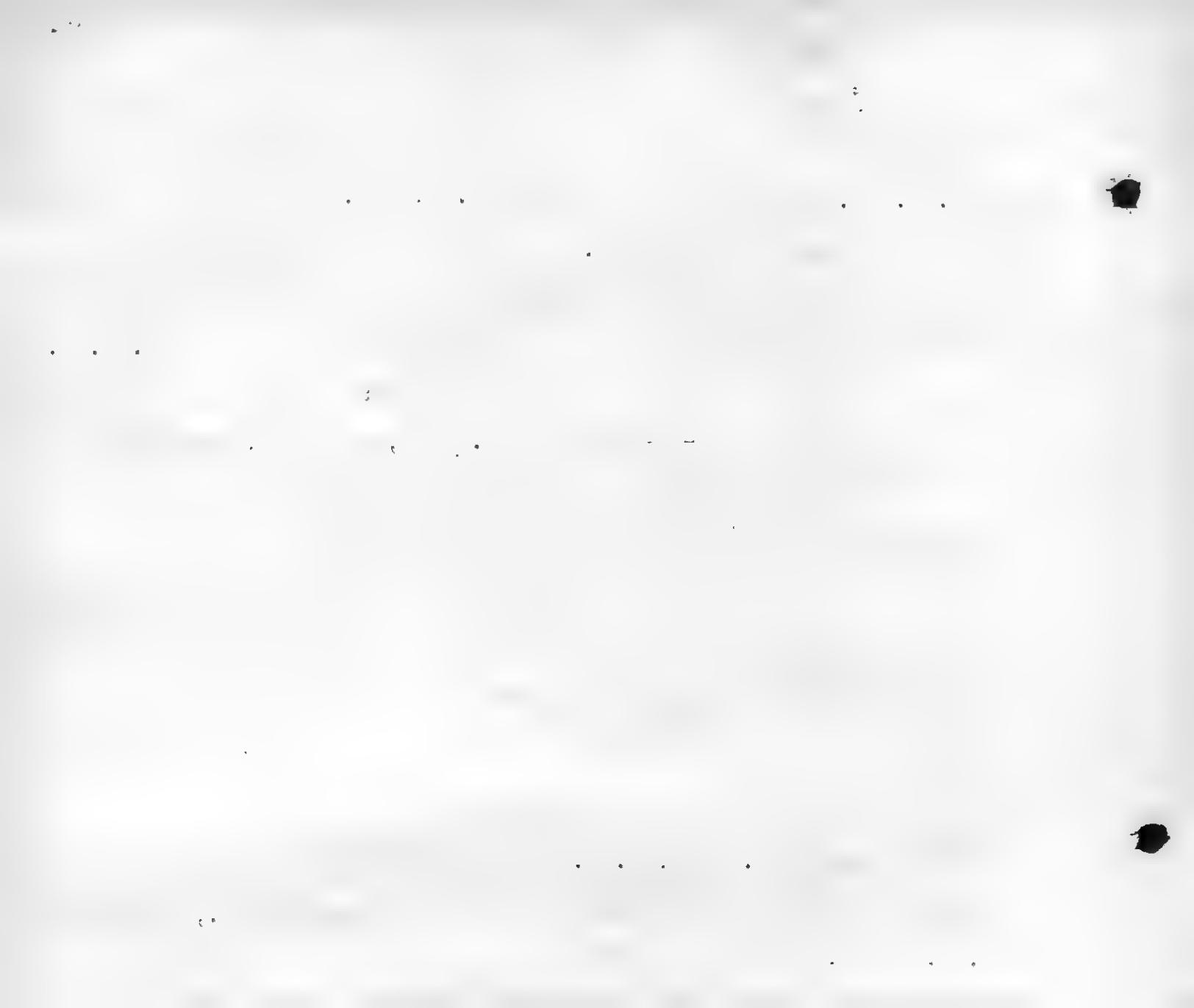
TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be ret'd by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be used with
 Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be used with
 the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10136 10127

| | | | | | | | |
|---|----------------------------------|---|--|--|--|---|---------------------------------|
| 1. PLACE OF DEATH a. COUNTY Carroll | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland | | b. COUNTY Carroll | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Harrisville | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Harrisville | | d. STREET ADDRESS R. D. Mt. Airy | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R. D. Mt. Airy | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) | First VIOLA | Middle R. | Last HOOD | 4. DATE OF DEATH | Month September | Day 11 | Year 1960 |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | B. DATE OF BIRTH February 24, 1895 | 9. AGE (In years lost birthday) 65 | IF UNDER 1 YEAR Months 65 | IF UNDER 24 HRS. Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Examiner Coat Factory | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Unknown | | 14. MOTHER'S MAIDEN NAME Ella Owings | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No | | 16. SOCIAL SECURITY NO. 220-26-0193 | | 17. INFORMANT Carl R. Hood, Mt. Airy, Maryland | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260X | | <i>Coronary thrombosis, arteriosclerotic 1959</i> | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first | | <i>Heart disease, arteriosclerosis generalized to Arterio-mallathis - 1960</i> | | | | | |
| DUE TO (b) DUE TO (c) | | | | | | | |
| PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from _____ to _____, that (I) (we) last saw the deceased alive on _____, and that death occurred at 11:50 AM 1960 , M, from the causes and on the date stated above. | | 1908 19 to 11 Sept 1960 | | | | | |
| 22a. SIGNATURE <i>Howard E. Hall</i> | | M.D. | | ATTENDING PHYS. <input type="checkbox"/> | MED. DIRECTOR <input type="checkbox"/> | STAFF PHYS. <input type="checkbox"/> | 22b. DATE SIGNED 1960 |
| 22c. PHYSICIAN'S NAME (Type) Howard E. Hall, M. D. | | 22d. ADDRESS Sykesville, Maryland | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Sept. 14, 1960 | | 23c. NAME OF CEMETERY OR CREMATORIUM Prospect Cemetery | | 23d. LOCATION (City, town, or county) Frederick Co., Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz, Winfield, Maryland | | ADDRESS | | 25a. REC'D BY REGISTRAR DATE SEP 14 '60 | | 25b. REGISTRAR'S SIGNATURE Clifford S. Thomas | |

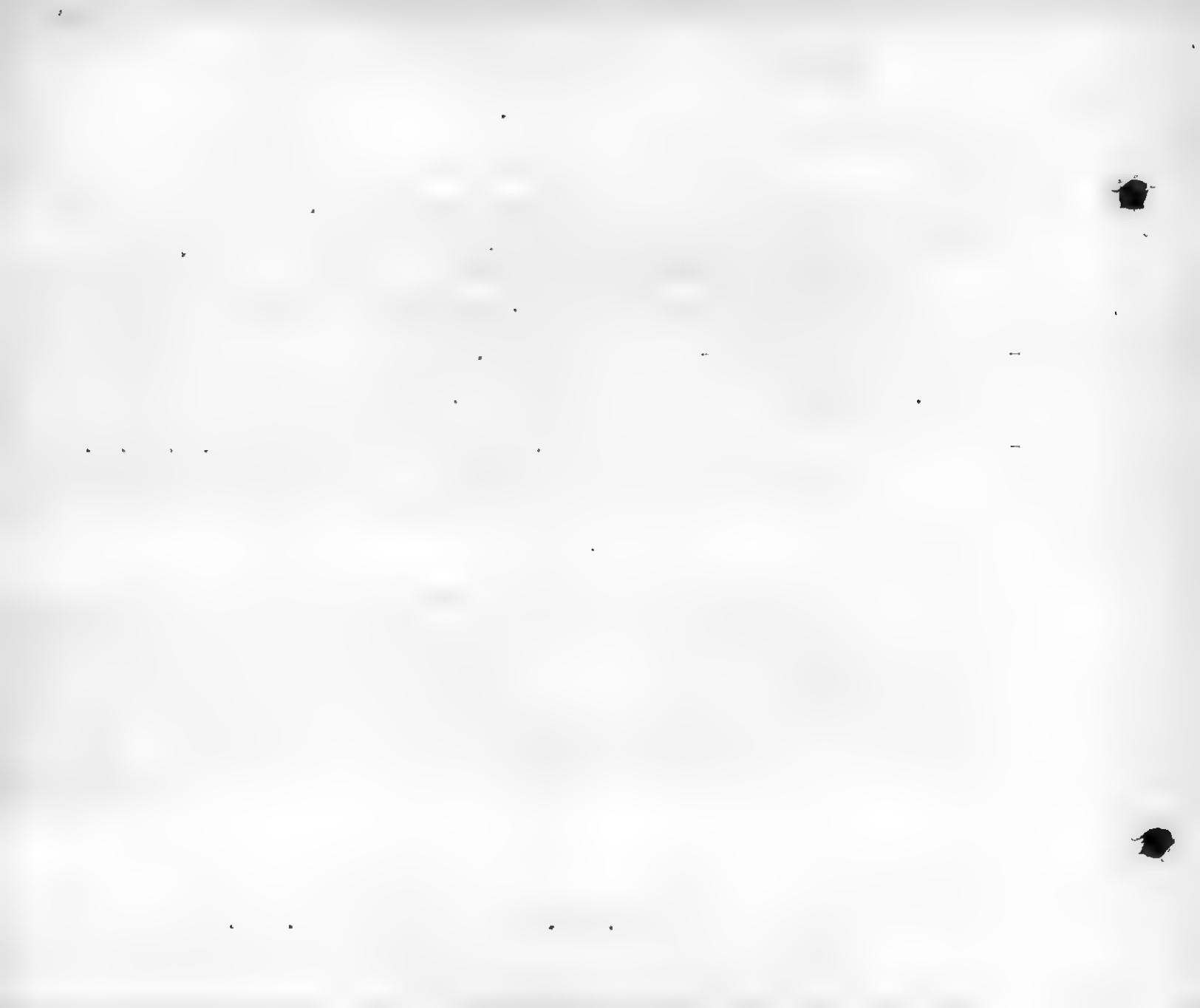


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10128

| | | | | | | | | |
|--|----------------------------------|--|--|---|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Carroll | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) b. STATE Md. | | b. COUNTY | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Winfield | | c. LENGTH OF STAY IN 1b RURAL and give nearest town) | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Golden Age Nursing Home | | | | d. STREET ADDRESS 3919 Edmondson Ave. | | d. STREET ADDRESS | | |
| 3. NAME OF DECEASED (Type or print) MARIE | | First | Middle ELIZABETH | Last HOPKINS | 4. DATE OF DEATH Sept. 6, 1960 | Month Sept. | Day 6 | Year 1960 |
| S. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH Dec. 24, 1897 | 9. AGE (In years lost birthday) 62 | 10. IF UNDER 1 YEAR Months 0 | 11. IF UNDER 24 HRS Days 0 | 12. IF UNDER 24 HRS Hours 0 | 13. IF UNDER 24 HRS Min 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Md. | | 12. CITIZEN OF WHAT COUNTRY? | | |
| 13. FATHER'S NAME Albert J. Volkmann | | 14. MOTHER'S MAIDEN NAME Emma L. Winter | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | |
| | | | | Mr. Fred Volkmann - Syosset, L. I., N. Y. | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 163 X DUE TO Acute Cardiac Failure INTERVAL BETWEEN Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Malignancy of lungs (c) 3 yrs ONSET AND DEATH | | | | | | | | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) PERFORMED? (If yes, give date or dates of service) YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) Balto. | | (County) Md. (State) |
| 21. I certify that (I) (this hospital) attended the deceased from Aug 22 1960 to Sept 6 1960 that (I) (we) last saw the deceased alive on Aug 25 1960 and that death occurred at Balto. M. from the causes and on the date stated above. | | | | | | | | |
| 22a. SIGNATURE Morell L. Martin | | M. D. ATTENDING PHYS. <input type="checkbox"/> | | MED. DIRECTOR <input type="checkbox"/> | | STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED Sept 7 1960 |
| 22c. PHYSICIAN'S NAME (Type) MARRELL L. MARTIN | | 22d. ADDRESS Sykesville Md. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 9/8/60 | | 23c. NAME OF CEMETERY OR CREMATORIAL Balto. Cem. | | 23d. LOCATION (City, town, or county) Balto., Md. | | (State) |
| 24. FUNERAL DIRECTOR'S SIGNATURE John J. Tickner & Sons - Balto. | | ADDRESS 17 N.W. | | 25a. REC'D BY REGISTRAR DATE SEP 7 '60 | | 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus | | |



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10158

1. PLACE OF DEATH
a. COUNTY *Berwyn* b. STATE *MARYLAND*

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) *Saint Roseville Rural* c. LENGTH OF STAY IN 1b *10 days*

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION *Galena Ags. Conv. Home*

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE *Maryland* b. COUNTY *Baltimore*

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) *Maryland* d. STREET ADDRESS *Marie Street*

3. NAME OF DECEASED (Type or print) First *MARCELLA* Middle *KELLER* Last *Sept 24. 1960*

4. DATE OF DEATH Month *Sept* Day *24* Year *1960*

5. SEX *W* **6. COLOR OR RACE** *W* **7. MARRIED** **NEVER MARRIED** **WIDOWED** **DIVORCED**

8. DATE OF BIRTH *May 22-1873* **9. AGE (In years last birthday)** *87* **10. IF UNDER 1 YEAR** **11. IF UNDER 24 HRS.**
Months *0* Days *0* Hours *0* Min *0*

10a. USUAL OCCUPATION (Give kind of work done during past 5 years, working life, even if retired) *Housewife* **10b. KIND OF BUSINESS OR INDUSTRY** *own home* **10c. BIRTHPLACE (State or foreign country)** *Maryland* **12. CITIZEN OF WHAT COUNTRY?** *U.S.A.*

13. FATHER'S NAME *William J. Keller* **14. MOTHER'S MAIDEN NAME** *Elizabeth Albaugh*

15. WAS DECEASED EVER IN U.S. ARMED FORCES? *No* **16. SOCIAL SECURITY NO.** *No* **17. INFORMANT** *Eliza Short - Manchester Md* **Address**

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] **PART I. DEATH WAS CAUSED BY:** *Chronic Myocarditis* **INTERVAL BETWEEN ONSET AND DEATH** *1 week*
IMMEDIATE CAUSE (a) *443X* **DUE TO** *Myocarditis* **10 yrs**
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. *(b) ... (c)*

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) *Locality, Institutional, Malnutrition* **19. WAS AN AUTOPSY PERFORMED?** *NO*

20a. ACCIDENT WAS UNDERLYING **OR CONTRIBUTING** **CAUSE OF DEATH** *(If either, notify medical examiner)*

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) *Sept 20, 1960, to Sept 29, 1960*

20c. TIME OF INJURY Month, Day, Year **20d. INJURY OCCURRED** **20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.) **20f. (City or town)** **(County)** **(State)**
Hour o. m. 19 While at work Not while at work

21. I certify that (I) (this hospital) attended the deceased from *Sept 24, 1960* **to** *Sept 29, 1960*, **that (I) (we) last saw the deceased alive on** *Sept 24, 1960*, **and that death occurred at** *35M* **from the causes and on the date stated above**

22a. SIGNATURE *Marcella J. Keller* **22b. DATE SIGNED** *Sept 29, 1960*

22c. PHYSICIAN'S NAME (Type) *MARCELLA J. KELLER* **22d. ADDRESS** *Highsville Rd*

23a. BURIAL, CREMATION, REMOVAL (Specify) *Burial* **23b. DATE THEREOF** *9-27-60* **23c. NAME OF CEMETERY OR CREMATORIUM** *Maryland* **23d. LOCATION (City, town, or county)** *Berwyn* **(State)**

24. FUNERAL DIRECTOR'S SIGNATURE *Edgar W. Martin* **ADDRESS** *Hampstead Md* **25a. REC'D BY REGISTRAR** **25b. REGISTRAR'S SIGNATURE**
DATE *SEP 30 '60* *Arthur S. Kraus*



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10130

CERTIFICATE OF DEATH

Reg. Dist. No. 10130

TO HOSPITAL
may be referred
by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 4

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY CARRICK | | 2. USUAL RESIDENCE (Where deceased lived if institution or residence before admission) a. STATE MARYLAND | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) UNION BRIDGE | | c. LENGTH OF STAY IN 1b YEARS | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | e. STREET ADDRESS X UNION BRIDGE | |
| 3. NAME OF DECEASED (Type or print) HARRY DANIEL KOONS | | First | Middle |
| 4. DATE OF DEATH SEPT 1 1960 | | Last | Month Day Year |
| 5. SEX MALE | | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH 1/17/1900 |
| 8. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. AGE (In years lost birthday) 60 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired). MILLER-CEMENT PLANT | | 10b. KIND OF BUSINESS OR INDUSTRY MILLER-CEMENT PLANT | |
| 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME JOHN KOONS | | 14. MOTHER'S MAIDEN NAME VIRGINIA GILBERT | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. 213-03-1030 | |
| 17. INFORMANT MARY KOON'S | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Ulceritis Chronic Myocarditis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c) | |
| 19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Hour o. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>May</u> , 19 <u>60</u> to <u>Sept 1, 1960</u> that I last saw the deceased alive on <u>Aug 30</u> , 19 <u>60</u> , and that death occurred at <u>7A</u> M. from the causes and on the date stated above ACTUAL SIGNATURE <u>J. N. Legg</u> M.D. ADDRESS (Street, city or town, state) T. H. LEGG M.D. UNION BRIDGE MD DATE SIGNED T. H. LEGG M.D. UNION BRIDGE MD 9-1-60 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 9/4/60 | 22c. NAME OF CEMETERY OR CREMATORIAL MT. VIEW |
| 22d. LOCATION (City, town, or county) UNION BRIDGE | | 22e. LOCATION (City, town, or county) (State) MD | |
| 23. FUNERAL DIRECTOR'S SIGNATURE M. Hartley & Sons Union Bridge, Md | | 24a. REC'D BY REGISTRAR DABEP 6 '60 | |
| 24b. REGISTRAR'S SIGNATURE Albert S. French | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 of 18, 1960, 1st

10131

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <i>Carroll</i> | | 2. USUAL RESIDENCE [Where deceased lived. If institution: residence before admission] a. STATE <i>Md</i> | |
| b. CITY OR TOWN [If outside corporate limits, write RURAL and give nearest town] <i>Westminster</i> | | c. LENGTH OF STAY IN 1b c. CITY OR TOWN [If outside corporate limits, write RURAL and give nearest town] <i>Westminster</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Private home</i> | | d. STREET ADDRESS <i>R.D #2</i> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <i>Samuel Gertine</i> | | First <i>S</i> | Middle <i>John</i> |
| 4. DATE OF DEATH <i>Sept 7 1960</i> | | Month <i>Sept</i> | Day <i>7</i> |
| 5. SEX <i>M</i> | | 6. COLOR OR RACE <i>White</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 8. DATE OF BIRTH <i>2/3/1877</i> | | 9. AGE (In years last birthday) <i>83</i> | 10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Hausseur</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Household</i> | |
| 11. BIRTHPLACE (State or foreign country) <i>Carroll Co Md</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 13. FATHER'S NAME <i>Samuel Gertine</i> | | 14. MOTHER'S MAIDEN NAME <i>Amelia Jeffo</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>None</i> | |
| 17. INFORMANT <i>Next of kin</i> | | Address <i>122 Westminster St. Westminster Md</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>434.4</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>Cardiac Disease (chronic)</i> | |
| DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.] | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m. | | 20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>House</i> |
| 20f. (City or town) <i>Hanover</i> | | (County) <i>Carroll</i> | |
| (State) <i>Md</i> | | | |
| 21. I certify that I attended the deceased from <i>Sept 7 1960</i> to <i>Sept 7 1960</i> that I last saw the deceased alive on <i>Sept 7 1960</i> and that death occurred at <i>2 P.M.</i> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>George R. Ard</i> | | ADDRESS (Street, city or town, state) <i>M.D. Hanover Pa</i> | |
| PHYSICIAN'S NAME (Type) <i>Frederick Bucker Hanover</i> | | DATE SIGNED <i>George R. Ard</i> | |
| 22a. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i> | | 22b. DATE THEREOF <i>9/10/60</i> | 22c. NAME OF CEMETERY OR CEMATORIUM <i>Bethel New Haven</i> |
| 22d. LOCATION (City, town, or county) <i>Carroll Co Md</i> | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Frederick Bucker Hanover</i> | | 24a. REC'D BY REGISTRAR DATE <i>SEP 13 '60</i> | 24b. REGISTRAR'S SIGNATURE <i>John R. Kline</i> |

TO HOSPITAL by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10132

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | | | |
|--|--|---|--|--|--|--|--|-----------------------------|--|
| 1. PLACE OF DEATH a. COUNTY CARROLL | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROUTE #7 | | c. LENGTH OF STAY IN lb 60 YEARS | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND | | b. COUNTY CARROLL | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROUTE #7 WE STMINSTER | | | |

| | | | | | | | |
|--|-----------------------|------------------------|-----------------------|--|---------------------------|------------------|---------------------|
| 3. NAME OF DECEASED (Type or print) | First MAUDE | Middle ALICE | Last LAWYER | 4. DATE OF DEATH SEPTEMBER 26 1960 | Month SEPTEMBER | Day 26 | Year 1960 |
|--|-----------------------|------------------------|-----------------------|--|---------------------------|------------------|---------------------|

| | | | | | | |
|-------------------------|----------------------------------|---|--|--|--|---|
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH SEPT. 29 1879 | 9. AGE (In years last birthday) 80 yrs. | 11. BIRTHPLACE (State or foreign country) Carroll Co Md. | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
|-------------------------|----------------------------------|---|--|--|--|---|

| | | | |
|--|-----------------------------------|--|---|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house - wife | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Carroll Co Md. | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
|--|-----------------------------------|--|---|

| | |
|--|---|
| 13. FATHER'S NAME Andrew Myers | 14. MOTHER'S MAIDEN NAME Maudilla Myers |
|--|---|

| | | |
|---|---|--|
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | 16. SOCIAL SECURITY NO. ? (If yes, give war or dates of service) | 17. INFORMANT Miss Judith M. Lawyer, address |
|---|---|--|

| | | |
|--|--|--|
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | INTERVAL BETWEEN ONSET AND DEATH 12 HOURS |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | CORONARY THROMBOSIS |
| Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. | | |
| { (b) (c) | | |
| DUE TO | | ARTERIOSCLEROTIC CARDIOVASCULAR DIS. 5 YEARS |
| DUE TO | | |
| (c) | | |

| | | |
|--|--|---|
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
|--|--|---|

| | | | | |
|---|--|---|--|---|
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) | | | |
| 20c. TIME OF INJURY Hour a. m. p. m. | Month, Day, Year 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |

| |
|---|
| 21. I certify that I attended the deceased from APRIL 1959 to SEPT 1960 , that I last saw the deceased alive on SEPTEMBER 26 1960 , and that death occurred at 10:30 A.M. from the causes and on the date stated above. |
|---|

ADDRESS (Street, city or town, state)

DATE SIGNED

| | | | |
|--|--|----------------------|----------------|
| ACTUAL SIGNATURE Daniel T. Welliver | M.D. | 19 RIDGE ROAD | 9/26/60 |
| PHYSICIAN'S NAME (Type) | DANIEL T. WELLIVER MD. WESTMINSTER MARYLAND | | |

| | | | |
|---|-------------------------------------|--|--|
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation | 22b. DATE THEREOF 9/29/60 | 22c. NAME OF CEMETERY OR Crematorium Meadow Branch Crematorium | 22d. LOCATION (City, town, or county) Westminster, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE J. S. Myers, Jr., Westminster, Md. | ADDRESS | 24a. REC'D BY REGISTRAR DATE SEP 28 '60 | 24b. REGISTRAR'S SIGNATURE Linber & Trahan |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10161

CERTIFICATE OF DEATH

10133

Reg. Dist. No.

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|--|-------------------------------|---|---------------------------------|
| 1. PLACE OF DEATH a. COUNTY CARROLL | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) b. STATE MARYLAND b. COUNTY CARROLL | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER RURAL YEARS | | c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER RURAL | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) HELENA FRANCES LOGUE | | First | Middle |
| 4. DATE OF DEATH Month Year | Month | Day | Year |
| 5. SEX F | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH SEPT 9-1872 |
| 9. AGE (In years last birthday) 87 yrs | 10. IF UNDER 1 YEAR Months | 11. IF UNDER 24 HRS Days | 12. Hrs |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10b. KIND OF BUSINESS OR INDUSTRY OWN HOME | |
| 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME GEORGE FREYMAN | | 14. MOTHER'S MAIDEN NAME MARGARET JULIE | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? <input type="checkbox"/> (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. NONE | |
| 17. INFORMANT GERTIE LOGUE | | Address 176 WESTMINSTER | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 440X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Diseases after a Sclerotic CardioVascular Disease | | | |
| Cerebral Hemorrhage | | | |
| INTERVAL BETWEEN ONSET AND DEATH 7 days | | | |
| several yrs | | | |
| several yrs | | | |
| several yrs | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| DUE TO mild Hypertension | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>August 26 1960</u> to <u>Sept 1 1960</u> that I last saw the deceased alive on <u>Sept 1 1960</u> , and that death occurred at <u>1105 PM</u> from the causes and on the date stated above. | | | |
| ADDRESS (Street, city or town, state) ACTUAL SIGNATURE M.D. PHYSICIAN'S NAME (Type) IV GLENN SPEICHER WESTMINSTER MD | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF SEPT 3-1960 | |
| 22c. NAME OF CEMETERY OR CREMATORIAL TRINITY LUTHERAN | | 22d. LOCATION (City, town, or county) CARROLL CO MD | |
| 23. FUNERAL DIRECTOR'S SIGNATURE D. Hargrave & Sons New Windsor, Md | | 24a. REC'D BY REGISTRAR DATE SEP 6 '60 | |
| | | 24b. REGISTRAR'S SIGNATURE Arthur J. Marshall | |



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10134

CERTIFICATE OF DEATH

| | | | |
|--------------------------------|--|---|--|
| 1. PLACE OF DEATH a. COUNTY | | 10162 Items 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000, 1001, 1002, 1003, 1004, 1005, 1006, 1007, 1008, 1009, 1000, 1001, 1002, 1003, 1004, 1005, 1006, 1007, 1008, 1009, 1010, 1011, 1012, 1013, 1014, 1015, 1016, 1017, 1018, 1019, 1010, 1011, 1012, 1013, 1014, 1015, 1016, 1017, 1018, 1019, 1020, 1021, 1022, 1023, 1024, 1025, 1026, 1027, 1028, 1029, 1020, 1021, 1022, 1023, 1024, 1025, 1026, 1027, 1028, 1029, 1030, 1031, 1032, 1033, 1034, 1035, 1036, 1037, 1038, 1039, 1030, 1031, 1032, 1033, 1034, 1035, 1036, 1037, 1038, 1039, 1040, 1041, 1042, 1043, 1044, 1045, 1046, 1047, 1048, 1049, 1040, 1041, 1042, 1043, 1044, 1045, 1046, 1047, 1048, 1049, 1050, 1051, 1052, 1053, 1054, 1055, 1056, 1057, 1058, 1059, 1050, 1051, 1052, 1053, 1054, 1055, 1056, 1057, 1058, 1059, 1060, 1061, 1062, 1063, 1064, 1065, 1066, 1067, 1068, 1069, 1060, 1061, 1062, 1063, 1064, 1065, 1066, 1067, 1068, 1069, 1070, 1071, 1072, 1073, 1074, 1075, 1076, 1077, 1078, 1079, 1070, 1071, 1072, 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1159, 1160, 1161, 1162, 1163, 1164, 1165, 1166, 1167, 1168, 1169, 1160, 1161, 1162, 1163, 1164, 1165, 1166, 1167, 1168, 1169, 1170, 1171, 1172, 1173, 1174, 1175, 1176, 1177, 1178, 1179, 1170, 1171, 1172, 1173, 1174, 1175, 1176, 1177, 1178, 1179, 1180, 1181, 1182, 1183, 1184, 1185, 1186, 1187, 1188, 1189, 1180, 1181, 1182, 1183, 1184, 1185, 1186, 1187, 1188, 1189, 1190, 1191, 1192, 1193, 1194, 1195, 1196, 1197, 1198, 1199, 1190, 1191, 1192, 1193, 1194, 1195, 1196, 1197, 1198, 1199, 1200, 1201, 1202, 1203, 1204, 1205, 1206, 1207, 1208, 1209, 1200, 1201, 1202, 1203, 1204, 1205, 1206, 1207, 1208, 1209, 1210, 1211, 1212, 1213, 1214, 1215, 1216, 1217, 1218, 1219, 1210, 1211, 1212, 1213, 1214, 1215, 1216, 1217, 1218, 1219, 1220, 1221, 1222, 1223, 1224, 1225, 1226, 1227, 1228, 1229, 1220, 1221, 1222, 1223, 1224, 1225, 1226, 1227, 1228, 1229, 1230, 1231, 1232, 1233, 1234, 1235, 1236, 1237, 1238, 1239, 1230, 1231, 1232, 1233, 1234, 1235, 1236, 1237, 1238, 1239, 1240, 1241, 1242, 1243, 1244, 1245, 1246, 1247, 1248, 1249, 1240, 1241, 1242, 1243, 1244, 1245, 1246, 1247, 1248, 1249, 1250, 1251, 1252, 1253, 1254, 1255, 1256, 1257, 1258, 1259, 1250, 1251, 1252, 1253, 1254, 1255, 1256, 1257, 1258, 1259, 1260, 1261, 1262, 1263, 1264, 1265, 1266, 1267, 1268, 1269, 1260, 1261, 1262, 1263, 1264, 1265, 1266, 1267, 1268, 1269, 1270, 1271, 1272, 1273, 1274, 1275, 1276, 1277, 1278, 1279, 1270, 1271, 1272, 1273, 1274, 1275, 1276, 1277, 1278, 1279, 1280, 1281, 1282, 1283, 1284, 1285, 1286, 1287, 1288, 1289, 1280, 1281, 1282, 1283, 1284, 1285, 1286, 1287, 1288, 1289, 1290, 1291, 1292, 1293, 1294, 1295, 1296, 1297, 1298, 1299, 1290, 1291, 1292, 1293, 1294, 1295, 1296, 1297, 1298, 1299, 1300, 1301, 1302, 1303, 1304, 1305, 1306, 1307, 1308, 1309, 1300, 1301, 1302, 1303, 1304, 1305, 1306, 1307, 1308, 1309, 1310, 1311, 1312, 1313, 1314, 1315, 1316, 1317, 1318, 1319, 1310, 1311, 1312, 1313, 1314, 1315, 1316, 1317, 1318, 1319, 1320, 1321, 1322, 1323, 1324, 1325, 1326, 1327, 1328, 1329, 1320, 1321, 1322, 1323, 1324, 1325, 1326, 1327, 1328, 1329, 1330, 1331, 1332, 1333, 1334, 1335, 1336, 1337, 1338, 1339, 1330, 1331, 1332, 1333, 1334, 1335, 1336, 1337, 1338, 1339, 1340, 1341, 1342, 1343, 1344, 1345, 1346, 1347, 1348, 1349, 1340, 1341, 1342, 1343, 1344, 1345, 1346, 1347, 1348, 1349, 1350, 1351, 1352, 1353, 1354, 1355, 1356, 1357, 1358, 1359, 1350, 1351, 1352, 1353, 1354, 1355, 1356, 1357, 1358, 1359, 1360, 1361, 1362, 1363, 1364, 1365, 1366, 1367, 1368, 1369, 1360, 1361, 1362, 1363, 1364, 1365, 1366, 1367, 1368, 1369, 1370, 1371, 1372, 1373, 1374, 1375, 1376, 1377, 1378, 1379, 1370, 1371, 1372, 1373, 1374, 1375, 1376, 1377, 1378, 1379, 1380, 1381, 1382, 1383, 1384, 1385, 1386, 1387, 1388, 1389, 1380, 1381, 1382, 1383, 1384, 1385, 1386, 1387, 1388, 1389, 1390, 1391, 1392, 1393, 1394, 1395, 1396, 1397, 1398, 1399, 1390, 1391, 1392, 1393, 1394, 1395, 1396, 1397, 1398, 1399, 1400, 1401, 1402, 1403, 1404, 1405, 1406, 1407, 1408, 1409, 1400, 1401, 1402, 1403, 1404, 1405, 1406, 1407, 1408, 1409, | |
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10163

CERTIFICATE OF DEATH

10135

| | | | | | |
|--|-------------------------------|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <i>Garrett</i> | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <i>Michigan</i> b. COUNTY <i>Garrett</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Milford</i> | | c. LENGTH OF STAY IN lb <i>50 yrs.</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Milford</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>—</i> | | d. STREET ADDRESS <i>—</i> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <i>KATIE H. MILLER</i> | | 4. DATE OF DEATH Month <i>Sept</i> Day <i>22</i> Year <i>1960</i> | | | |
| S. SEX <i>W</i> | 5. COLOR OR RACE <i>LO</i> | 6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <i>July 27-1885</i> | 7. AGE (In years last birthday) <i>75 yrs.</i> | 8. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> | 9. IF UNDER 24 HRS Hours <i>0</i> Min. <i>0</i> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>own house</i> | | 11. BIRTHPLACE (State or foreign country) <i>England</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | | | | |
| 13. FATHER'S NAME <i>Wilson Garrett</i> | | 14. MOTHER'S MAIDEN NAME <i>Matilda West</i> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> | | 16. SOCIAL SECURITY NO <i>219-03-6287</i> | | 17. INFORMANT Address <i>— Everett Miller, Miller Rd, Garrett, Md</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>420.0</i> | | DUE TO <i>Arteriosclerotic Heart Disease</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>2 yrs</i> | |
| Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>(b)</i> | | DUE TO <i>(c)</i> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <i>—</i> | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, Farm, factory, street, office bldg., etc.) <i>20f. (City or town) (County) (State) Manchester, Md</i> | |
| 21. I certify that (I) (this hospital) attended the deceased from <i>April</i> 1948, to <i>Sept 22</i> 1960, that (I) (we) last saw the deceased alive on <i>Sept 17</i> 1960, and that death occurred at <i>7A M.</i> from the causes and on the date stated above. | | | | 22b. DATE SIGNED | |
| 22a. SIGNATURE <i>W H Foard</i> | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | |
| 22c. PHYSICIAN'S NAME (Type) <i>W H Foard M.D.</i> | | 22d. ADDRESS <i>Manchester, Md</i> | | 22e. DATE <i>9-22-60</i> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 23b. DATE THEREOF <i>9-24-60</i> | | 23c. NAME OF CEMETERY OR CREMATORIAL <i>Hospital</i> | |
| 23d. LOCATION (City, town, or county) <i>Garrett, Md</i> | | | | (State) | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <i>Edgar S. Kress</i> | | ADDRESS <i>Edgar S. Kress 14 Acorn Brook Rd</i> | | 25a. REC'D BY REGISTRAR DATE <i>SEP 26 '60</i> | |
| | | | | 25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kress</i> | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10136

CERTIFICATE OF DEATH

Reg. Dist. No.

10164

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be read by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please ~~remove~~ carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 1/2 hours after death.

| | | | | | | | | | | | | | | |
|---|----------------------------------|--|---|--|--|--|-----|--|---|--|---------------------------------|----------------------|---------------------|---|
| 1. PLACE OF DEATH a. COUNTY <i>Carroll</i> | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Westminster, Md.</i> | | c. LENGTH OF STAY IN 1b <i>14 yrs</i> | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i> | | b. COUNTY <i>College Hill</i> | | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>College Hill</i> | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>College Hill</i> | | f. STREET ADDRESS <i>College Hill</i> | | g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) <i>MAHLON FRANK</i> | | First | Middle | Last | 4. DATE OF DEATH <i>PECK SEPT. 12 1960</i> | Month | Day | Year | | | | | | |
| 5. SEX <i>Male</i> | 6. COLOR OR RACE <i>White</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>MAY 18, 1913</i> | | 9. AGE (In years last birthday) <i>47 yrs</i> | 10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min | | | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>COLLEGE Professor</i> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>LOCKPORT NEW YORK</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | | | | | | | |
| 13. FATHER'S NAME <i>HARRY L. PECK</i> | | 14. MOTHER'S MOTHER'S MAIDEN NAME <i>Jessie Tucker</i> | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no, or unknown) <i>—</i> | | 16. SOCIAL SECURITY NO. <i>712-14-56477</i> | | | 17. INFORMANT <i>M. L. Peck, Westminster, Md. RO#7</i> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> | | DUE TO <i>MYOCARDIAL INFARCTION</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>1 MIN.</i> | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>—</i> | | (b) <i>CORONARY SCLEROSIS</i> | | (c) <i>—</i> | | 7 MOS. | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c) | | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY Hour a. m. <i>19</i> p. m. <i>—</i> Month <i>—</i> Day <i>—</i> Year <i>1960</i> | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i> | 20f. (City or town) <i>—</i> | (County) <i>—</i> | (State) <i>—</i> | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21. I certify that I attended the deceased from <i>Febr. 1960</i> to <i>Sept. 12, 1960</i> that I last saw the deceased alive on <i>Sept. 12, 1960</i> , and that death occurred at <i>10:30 A.M.</i> from the causes and on the date stated above. | | ACTUAL SIGNATURE <i>William L. Stewart, M.D.</i> | | ADDRESS (Street, city or town, state) <i>19 RIDGE RD., Westminster, Md.</i> | | DATE SIGNED <i>9/12/60</i> | | | | | | | | |
| PHYSICIAN'S NAME (Type) <i>WILLIAM L. STEWART, WESTMINSTER, MD.</i> | | 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 22b. DATE THEREOF <i>Sept. 15, 60</i> | | 22c. NAME OF CEMETERY OR CEMETORY <i>Midway Branch Rural</i> | | 22d. LOCATION (City, town, or county) <i>Westminster, Md.</i> | | (State) <i>—</i> | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>W. L. Stewart, M.D.</i> | | ADDRESS <i>820 Ridge Rd., Westminster, Md.</i> | | 24a. REC'D BY REGISTRAR <i>—</i> | | 24b. REGISTRAR'S SIGNATURE <i>—</i> | | DATE SEP 16 '60 | | — | | | | |



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10165 10137

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Carroll | | 2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE MARYLAND b. COUNTY City | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital | | d. STREET ADDRESS 628 E. 29th Street | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) Laura | First A. | Middle Placide | Last |
| 4. DATE OF DEATH September 1, 1960 | Month | Day | Year |
| S. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH Dec. 25, 1872 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) New York | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME Fred Moebius | | 14. MOTHER'S MAIDEN NAME Laura S. Nuss | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | 16. SOCIAL SECURITY NO | 17. INFORMANT Springfield Hospital Records | Address |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the stomach | | | |
| DUE TO (b) Arteriosclerotic cardiovascular disease. | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Schizophrenic reaction, paranoid type. | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b) | |
| 20c. TIME OF INJURY Hour o m 19 | Month March | Day 7 | Year 1955 |
| 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from March 7, 1955 , to Sept. 1, 1960 , that (I) (we) last saw the deceased alive on Septem. 1, 1960 , and that death occurred at 2:10 PM from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Agustine delCampo, M.D. | | 22b. MEDICAL STAFF ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> 9/1/60 | |
| 22c. PHYSICIAN'S NAME (Type) Agustine delCampo, M.D. | | 22d. ADDRESS Springfield Hospital, Sykesville, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE THEREOF 9/5/60 | 23c. NAME OF CEMETERY OR CREMATORIUM Loudon Pk. Cem. | 23d. LOCATION (City, town, or county) BALTO., Md. |
| 24. FUNERAL DIRECTOR'S SIGNATURE Hartley Miller, 2334 Jefferson St. | | 25a. ADDRESS Jefferson St. | 25b. REG'D BY REG STAR DATE SEP 6 '60 |
| | | 25c. REGISTRAR'S SIGNATURE Chet S. Fins. | |

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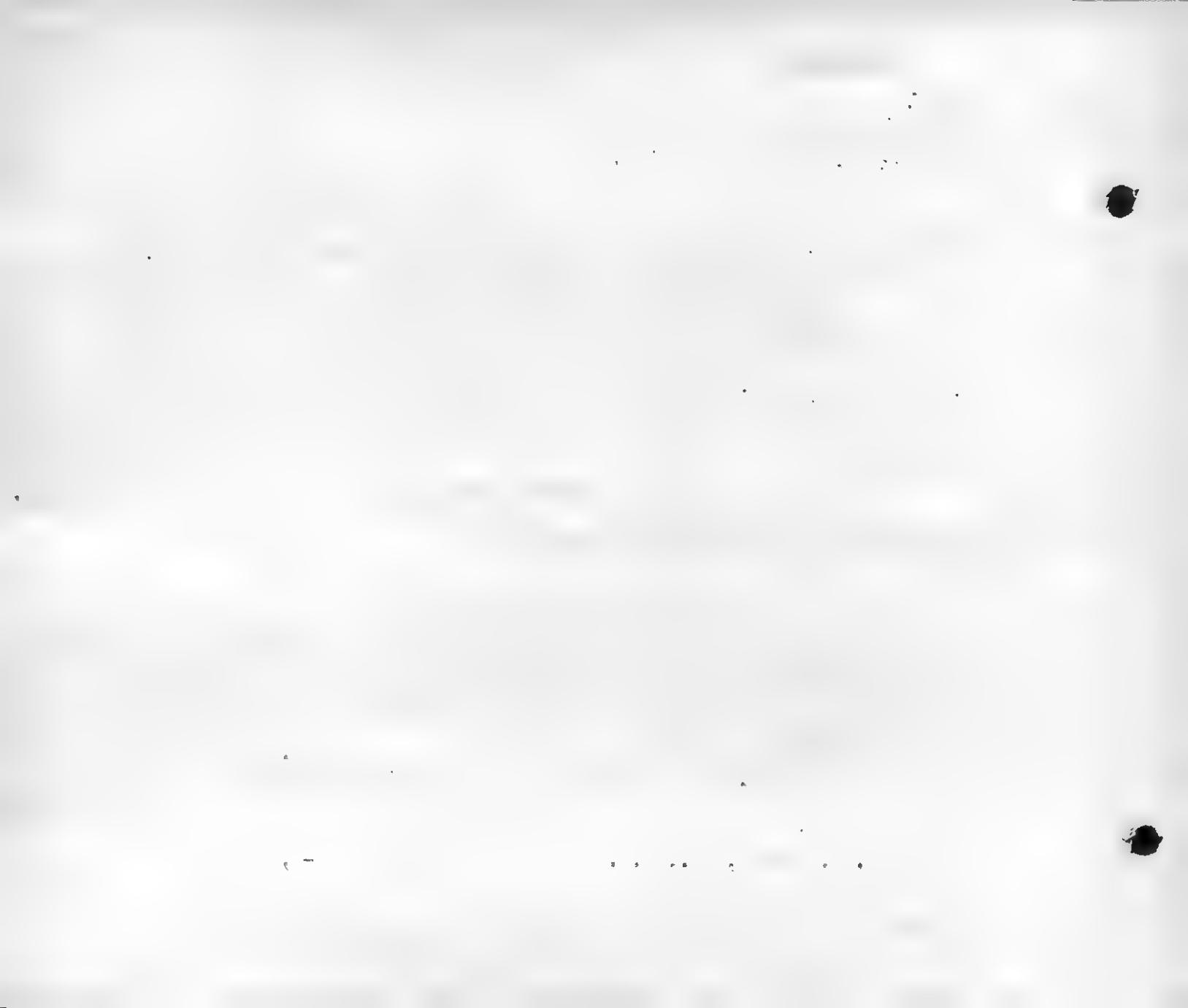
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10138

| | | | | | | | | | | | | | |
|--|--|--|--|---|--|---------------------------------------|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE | | Md. | | b. COUNTY | | Carroll | | | |
| b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Stephensville | | c. LENGTH OF STAY IN 1b 15 years | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stephensville | | STREET ADDRESS 130 - 2nd ave. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | 4. DATE OF DEATH | | Month | | Day | | Year | | | |
| 3. NAME OF DECEASED (Type or print) | | First | | Middle | | Last | | Month | | Year | | | |
| 5. SEX | | 6. COLOR OR RACE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH | | 9. AGE (In years last birthday) | | 10. IF UNDER 1 YEAR Months Days Hours Min. | | | |
| F. | | Bl | | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | April 13 1878 | | 82 yrs | | 11. IF UNDER 24 HRS. Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | | | | | | |
| Home | | | | Md. | | U.S.A. | | | | | | | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | | | | | | | | | | |
| William A. Shippley | | Catherine E. Shipler | | | | | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | | | | | | |
| No | | none | | Mrs. Willie Clifton Shippley, Md. | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HYPER TENSIVE CARDIOVASCULAR DISEASE with 443X XEROX Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) GENERAL ARTERIOSCLEROSIS and CHRONIC MYOCARDITIS DUE TO (c) | | | | | | | | | | | | | |
| 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) | | (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 1935, 19, to Sept. 30, 1960, that (I) (we) last saw the deceased alive on Sept. 29, 1960, and that death occurred at 1:15 AM from the causes and on the date stated above. | | | | | | | | | | | | | |
| 22a. SIGNATURE | | 22b. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | | | | | | |
| 22c. PHYSICIAN'S NAME (Type) | | 22d. ADDRESS | | 22e. DATE | | | | | | | | | |
| Wm. H. Lawson, Jr., M.D. | | Sykesville-2, Maryland | | 1960 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF | | 23c. NAME OF CEMETERY OR CREMATORIUM | | 23d. LOCATION (City, town, or county) | | (State) | | | | | |
| Burial | | 10-2-60 | | The Grove | | Mt. airy (and 16, Md.) | | | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| Arthur H. Haight | | Stephensville, Md. | | OCT 4 '60 | | Arthur S. Thomas | | | | | | | |



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10139

CERTIFICATE OF DEATH

| | | | |
|---|-------------------------------|---|---|
| 1 PLACE OF DEATH a. COUNTY Carroll | | 2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville | | c. LENGTH OF STAY IN 1b 10 yrs. 7 mos. 1 day | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print) | First John | Middle Ingram | Last Prince |
| 4 DATE OF DEATH | Month September | Day 2, | Year 1960 |
| 5 SEX Male | 6 COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH January 13, 1896 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Florist | | 10b. KIND OF BUSINESS OR INDUSTRY — | 11. BIRTHPLACE (State or foreign country) Maryland |
| 13. FATHER'S NAME Edmund G. Prince | | 14. MOTHER'S MAIDEN NAME Martha Virginia Lyons | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO — | 17. INFORMANT Springfield Hospital Records |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease | | INTERVAL BETWEEN ONSET AND DEATH Years | |
| DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. Generalized arteriosclerosis | | Years | |
| DUE TO (b) Generalized arteriosclerosis | | | |
| (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Involutional melancholia. | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour a. m. p. m. | Month 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 3/7/55 to Sept. 2, 1960, that (I) (we) last saw the deceased alive on Sept. 1, 1960, and that death occurred at 5:12 AM from the causes and on the date stated above. | | 22b. DATE SIGNED 9/2/60 | |
| 22a. SIGNATURE | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | |
| 22c. PHYSICIAN'S NAME (Type)/ Agustin del Campo, M.D. | | 22d. ADDRESS Springfield Hospital, Sykesville, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 9/5/1960 | 23c. NAME OF CEMETERY OR CREMATORIAL Prospect Hill | 23d. LOCATION (City, town, or county) Towson, Md. (State) |
| 24. FUNERAL DIRECTOR'S SIGNATURE E. Carter, Jr., CATONSVILLE, MD. | | ADDRESS CATONSVILLE MD. | 25a. REC'D BY REGISTRAR DATE SEP 7 '60 |
| | | | 25b. REGISTRAR'S SIGNATURE C. Carter, Jr., Jr. |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

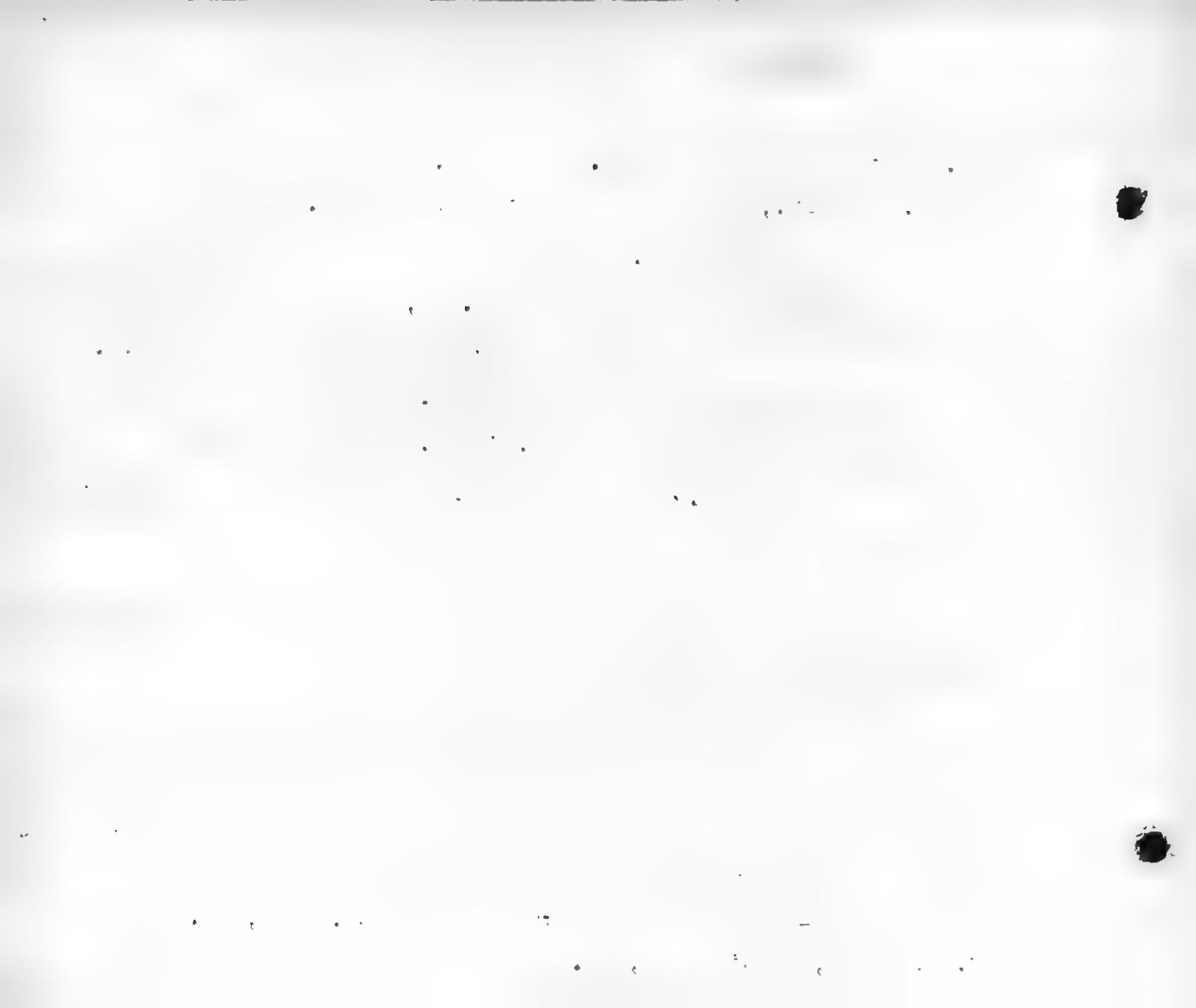
10140

19130

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | | | | |
|--|--|---|---|--|---|---|---|----------------------------------|------------------|---|
| 1. PLACE OF DEATH a. COUNTY Carroll | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institutional, Residence before admission) a. STATE Maryland | | b. COUNTY Carroll | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Airy | | c. LENGTH OF STAY IN 1b 20 yrs. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Airy | | d. STREET ADDRESS 625 S. Main St. | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 625 S. Main St., | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | |
| 3. NAME OF DECEASED (Type or print) ELSIE | | First ELSIE | Middle R. | Last ROBINSON | 4. DATE OF DEATH Sept 1, 1960 | Month Sept | Day 1 | Year 1960 | | |
| 5. SEX female | | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | B. DATE OF BIRTH Aug. 25, 1896 | 9. AGE (In years last birthday) 64 yrs | IF UNDER 1 YEAR Months 0 | IF UNDER 24 HRS. Days 0 | Hours 0 | Min. 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | 10b. KIND OF BUSINESS OR INDUSTRY home | | 11. BIRTHPLACE (State or foreign country) West Virginia | | 12. CITIZEN OF WHAT COUNTRY? U.S. | | | | |
| 13. FATHER'S NAME George Hedrick | | | | | 14. MOTHER'S MAIDEN NAME Mary C. Richardson | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. none | | INFORMANT Mr. Guy A. Robinson | | Address same | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerosis & hypertension</i> DUE TO <i>Heart Disease.</i> | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) 900 S. Main St. | | (State) Baltimore, Md. | | |
| 21. I certify that I attended the deceased from Sept 1, 1960 to Sept 1, 1960 that I last saw the deceased alive on Sept 1, 1960 , and that death occurred at 6:55 P.M. from the causes and on the date stated above. | | | | | | | | | | |
| ADDRESS (Street, city or town, state) 900 S. Main St., Mt. Airy, Md. | | | | | | | | | | |
| DATE SIGNED Sept 2, 1960 | | | | | | | | | | |
| ACTUAL SIGNATURE <i>W.B. Culwell</i> | | PHYSICIAN'S NAME (Type) W.B. Culwell, M.D. | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 9-4-1960 | | 22c. NAME OF CEMETERY OR CREMATORIUM Pine Grove | | 22d. LOCATION (City, town, or county) Mt. Airy, Md. | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz, | | | | | ADDRESS Winfield, Md. | | 24a. REC'D BY REGISTRAR DATE SEP 6 '60 | | | 24b. REGISTRAR'S SIGNATURE Arthur S. Thorne |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10168

CERTIFICATE OF DEATH

10141

Reg. Dist. No.

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY CARROLL | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MEADOW VIEW | | c. LENGTH OF STAY IN lb Westminster, MD 3 weeks | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEADOW VIEW COMMERCIAL HOME | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS BALTIMORE, MD 2765 ALAMEDA BLVD. | |
| 3. NAME OF DECEASED (Type or print) Laura AMELIA | | 4. DATE OF DEATH SEPT 3 1960 | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| S SEX Female | 5. COLOR OR RACE White | 6. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 7. B. DATE OF BIRTH DEC. 3, 1878 |
| 8. AGE (In years last birthday) 82 yrs. | | 9. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CASHIER | | 10b. KIND OF BUSINESS OR INDUSTRY DEP'T STORE | 11. BIRTHPLACE (State or foreign country) MARYLAND |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME LOUIS SCHUPP | |
| 14. MOTHER'S MOTHER'S NAME CAROLINE BROWNING | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No | |
| 16. SOCIAL SECURITY NO ? | | 17. INFORMANT Dr. Max J. Stein, M.D., Internist, 111 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c) | | CEREBRAL THROMBOSIS CARCINOMA OF BREAST WITH METASTASES TO Spleen & LUNGS | |
| INTERVAL BETWEEN ONSET AND DEATH 18 MOS | | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from alive on 9/2 1960 , and that death occurred at 8:30 A.M. from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) 19 RIDGE RD | |
| ACTUAL SIGNATURE William L. Stewart, M.D. | | DATE SIGNED 9/3/60 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Sept 6, 60 | |
| 22c. NAME OF CEMETERY OR CREMATORIAL Baltimore Cemetery | | 22d. LOCATION (City, town, or county) Baltimore | |
| 23. FUNERAL DIRECTOR'S SIGNATURE WILLIAM L. STEWART | | 24a. REC'D BY REGISTRAR DATE SEP 6 1960 | |
| ADDRESS 421 W. Pratt Street, Baltimore, Md. | | 24b. REGISTRAR'S SIGNATURE John S. Dunn | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10142

10169

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | | |
|--|---------------------------|---|-----------------------------|---|---|---|-----|------------------|
| 1. PLACE OF DEATH a. COUNTY Carroll | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland | | b. COUNTY | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville | | c. LENGTH OF STAY IN 1b 8Yrs. 5Mo. 7da. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital | | | | d. STREET ADDRESS 111 West Mulberry Street | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) Mae Rebecca | | First | Middle | Last | 4. DATE OF DEATH Sergent | Month | Day | Year |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH 5-28-86 | 9. AGE (In years lost birthday) 74 yrs | 10. UNDER 1 YEAR <input type="checkbox"/> 11. UNDER 24 HRS Months Days Hours Min | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY none | | 11. BIRTHPLACE (State or foreign country) Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME Joseph Stoker | | 14. MOTHER'S MAIDEN NAME Anna | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO none | | INFORMANT Miss Elizabeth Hanna | | Address 300 E. 30th St Balt., Md. | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) | | Arteriosclerotic Heart Disease | | | | INTERVAL BETWEEN ONSET AND DEATH years | | |
| 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. | | DUE TO (b) General Arteriosclerosis | | | | years | | |
| DUE TO (c) | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | Psychosis with cerebral arteriosclerosis (11 years) | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) (State) |
| 21. I certify that I attended the deceased from Sept. 10 th , 1966, to Sept. 20 th , 1966, that I last saw the deceased alive on Sept. 25 th , 1966, and that death occurred at 8:30P.M., from the causes and on the date stated above. | | | | | | ADDRESS (Street, city or town, state) | | DATE SIGNED |
| ACTUAL SIGNATURE Paul G. Koukoulias, M.D. | | | | | | Springfield State Hospital | | 9/28/66 |
| PHYSICIAN'S NAME (Type) Paul G. Koukoulias | | | | | | Sykesville, Maryland | | MD |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 9-29-60 | | 22c. NAME OF CEMETERY OR CREMATORIUM St. Peters Cemetery | | 22d. LOCATION (City, town, or county) Baltimore | | (State) |
| 23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street | | ADDRESS | | 24a. REC'D BY REGISTRAR DATE SEP 28 '60 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Krause | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10135 CERTIFICATE OF DEATH

Reg. Dist. No. **10143**

| | | | |
|---|-------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY Carroll | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE MARYLAND b. COUNTY Maryland Carroll | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster | | c. LENGTH OF STAY IN 1b 50 yrs? | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 19 W. Green St. | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster, Md. | |
| 3. NAME OF DECEASED (Type or print) WILLIAM A. SHAFFER | | 4. DATE OF DEATH Month SEPT. Day 1 Year 1960 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED June 29 1882 | 8. AGE (In years last birthday) 78 yrs |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter & Building supervisor | | 10b. KIND OF BUSINESS OR INDUSTRY Rural Westminster, Md. U.S.A | |
| 13. FATHER'S NAME Jeremiah Shaeffer | | 14. MOTHER'S MAIDEN NAME Alice Virginia Bush | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or date of service) None | | 16. SOCIAL SECURITY NO. 716-07-9223 INFORMANT Mrs. W. A. Shaeffer, 19 W. Green St., Westminster, Md. Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) | | DUE TO Hippot DUE TO Hippot | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 | | 20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) Westminster (County) Md. (State) | |
| 21. I certify that I attended the deceased from Sept. 4, 1960 to Sept. 4, 1960 , that I last saw the deceased alive on Sept. 4, 1960 , and that death occurred at 12 A.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Julius Shaeffer | | ADDRESS (Street, city or town, state) 19 W. Green St., Westminster, Md. DATE SIGNED Sept. 4, 1960 | |
| PHYSICIAN'S NAME (Type) Julius Shaeffer | | | |
| 22a. BURIAL, CREMATION ON REMOVAL (Specify) Burial | | 22b. DATE THEREOF Sept. 4, 1960 | |
| 22c. NAME OF CEMETERY OR CREMATORIAL Prideron Cemetery | | 22d. LOCATION (City, town, or county) Westminster, Md. (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE J. S. Myers, Jr., Westminster, Md. | | 24a. REC'D BY REGISTRAR Arthur S. Kimes DATE SEP 6 '60 | |
| | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kimes | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10136

CERTIFICATE OF DEATH

Reg. Dist. No.

10144

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <i>Charles</i> | | 2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE <i>MARYLAND</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i> | | c. LENGTH OF STAY IN b <i>75 years</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>316 George St.</i> | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i> | |
| 3. NAME OF DECEASED (Type or print) <i>MARY AGNES SHARP</i> | | 4. DATE OF DEATH Year <i>SEPT. 28 1960</i> | |
| 5. SEX <i>FEMALE</i> | | 6. COLOR OR RACE <i>WHITE</i> | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <i>MAY 13, 1885</i> | |
| 9. AGE (In years lost birthday) <i>75 yrs</i> | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 13. FATHER'S NAME <i>CHARLES THOMAS SHARP</i> | | 14. MOTHER'S MAIDEN NAME <i>Laura Haines</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? <i>No</i> | | 16. SOCIAL SECURITY NO. <i>123-45-6789</i> | |
| 17. INFORMANT <i>William L. Stewart, M.D.</i> | | Address <i>19 Ridge Rd, Westminster, Md.</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CEREBRAL THROMBOSIS</i> | | | |
| 33IX DUE TO | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>PARKINSONISM</i> | | | |
| DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>DEC 1959 to SEPT 28 1960</i> | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) <i>Westminster</i> (County) <i>Md.</i> (State) <i>Md.</i> | |
| 21. I certify that I attended the deceased from <i>DEC 1959</i> to <i>SEPT 28 1960</i> , that I last saw the deceased alive on <i>SEPT 28 1960</i> , and that death occurred at <i>509 M</i> , from the causes and on the date stated above. | | | |
| ADDRESS (Street, city or town, state) <i>19 Ridge Rd, Westminster, Md.</i> DATE SIGNED <i>9/28/60</i> | | | |
| ACTUAL SIGNATURE <i>William L. Stewart, M.D.</i> | | | |
| PHYSICIAN'S NAME (Type) <i>WILLIAM L. STEWART MD WESTMINSTER, MD</i> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i> | | 22b. DATE THEREOF <i>10/1/60</i> | |
| 22c. NAME OF CEMETERY OR CREMATORIAL <i>St. Paul's Cemetery</i> | | 22d. LOCATION (City, town, or county) <i>Westminster, Md.</i> (State) <i>Md.</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>W. M. Stewart, Jr.</i> | | ADDRESS <i>222 W. Main St., Westminster, Md.</i> | |
| 24a. REC'D BY REGISTRAR <i>REC'D 30 '60</i> | | 24b. REGISTRAR'S SIGNATURE <i>John S. Evans</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. *Age 1*
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
 ISM 9/55



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10145

10178

CERTIFICATE OF DEATH

M

1 PLACE OF DEATH
a. COUNTY

Carroll

MARYLAND

b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town)

Sykesville

c. LENGTH OF STAY IN 1b

1 mo. 6 days

d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION

Springfield State Hospital

3 NAME OF
DECEASED
(Type or print)First
Nellie
Middle
Louise
Last
Woods
Snoots4. DATE
OF
DEATHMonth
September
Day
26,
Year
1960

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

August 12, 1908

9. AGE (In years
at birthday)

52

10. IF UNDER 1 YEAR
IF UNDER 24 HRS

Months Days Hours Min

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

Homel

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Charles Woods

14. MOTHER'S MAIDEN NAME

Bessie Keller

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

- - -

17. INFORMANT

Address

Springfield Hospital Records

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a)

Congestive heart failure

INTERVAL BETWEEN
ONSET AND DEATH

Weeks

416X

DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

Congestive heart failure

(b)

DUE TO

Adhesive pericarditis

(c)

18 months.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
G.B.S. assoc. with unknown or uncertain cause. - Obesity.19. WAS AUTOPSY
PERFORMED?YES NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19
p. m.20d. INJURY OCCURRED
While Not while
at work at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from August 20, 1960, to Sept. 26, 1960, that (I) (we) last
saw the deceased alive on Sept. 25, 1960 and that death occurred at 7:00 AM from the causes and on the date stated above.

22a. SIGNATURE

Agustín del Campo

M.D.

ATTENDING
PHYS. MED
DIRECTOR STAFF
PHYS. 22b. DATE
9/26/6022c. PHYSICIAN'S
NAME (Type)

Agustín del Campo, M.D.

22d. ADDRESS

Springfield Hospital, Sykesville, Md.

23a. BURIAL, CREMATION,
REMOVAL (Specify)

9-28-60

23b. DATE THEREOF

4 years

23c. NAME OF CEMETERY OR CREMATORI

Governing

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

Foster A. Haught, Sykesville, Md.

ADDRESS

25a. REC'D BY REGISTRAR
DATE SEP 28 '6025b. REGISTRAR'S SIGNATURE
Arthur S. Evans



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10171

CERTIFICATE OF DEATH

10146

| | | | | | | | |
|--|---------------------------|--|---|--|--|--|----------------|
| 1. PLACE OF DEATH a. COUNTY Carroll | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE Maryland | | b. COUNTY Frederick | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville | | c. LENGTH OF STAY IN 1b 9 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middle Town, | | d. STREET ADDRESS None | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital | | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | First Edward | Middle Frank | Last Thompson | 4. DATE OF DEATH September 22, 1960 | Month September | Day 22 | Year 1960 |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH January 26, 1879 | | 9. AGE (In years last birthday) 81 yrs | F. UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter | | 10b. KIND OF BUSINESS OR INDUSTRY - | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Unknown | | 14. MOTHER'S MAIDEN NAME Unknown | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO - - - | |
| 17. INFORMANT Springfield Hospital Records | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Terminal bronchopneumonia | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | INTERVAL BETWEEN ONSET AND DEATH Days | |
| DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. | | (b) Arteriosclerotic cardiovascular disease | | | | Years | |
| (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) C.B.S. associated with arteriosclerosis. | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | | | |
| 20c. TIME OF INJURY Hour a. m. p. m. | Month 19 | Day | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) Springfield | (County) Frederick | (State) Md. |
| 21. I certify that (I) (this hospital) attended the deceased from Sept. 13, 1960, to Sept. 22, 1960, that (I) (we) last saw the deceased alive on Sept. 22, 1960, and that death occurred at 4:45 PM from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Agustin del Campo. | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 9/22/60 | | | |
| 22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D. | | 22d. ADDRESS Springfield Hospital, Sykesville, Md. | | | | | |
| 23a. BLRAL. CREMATION, REMOVAL (Specify) Burial. | | 23b. DATE THEREOF Sept. 25, 1960 | | 23c. NAME OF CEMETERY OR CREMATORIUM Brownsville Cemetery | | 23d. LOCATION (City, town, or county) Brownsville Wash. Co. MD | |
| 24. FUNERAL DIRECTOR'S SIGNATURE A. West | | ADDRESS Baltimore MD | | 25a. REC'D BY REGISTRAR OCT 3 '60 | | 25b. REGISTRAR'S SIGNATURE Arthur S. K. Jr. | |

TO HOSPITAL or **ATTENDING PHYSICIAN**: The law requires that the death certificate be executed within 24 hours after death. **TO FUNERAL DIRECTOR**: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

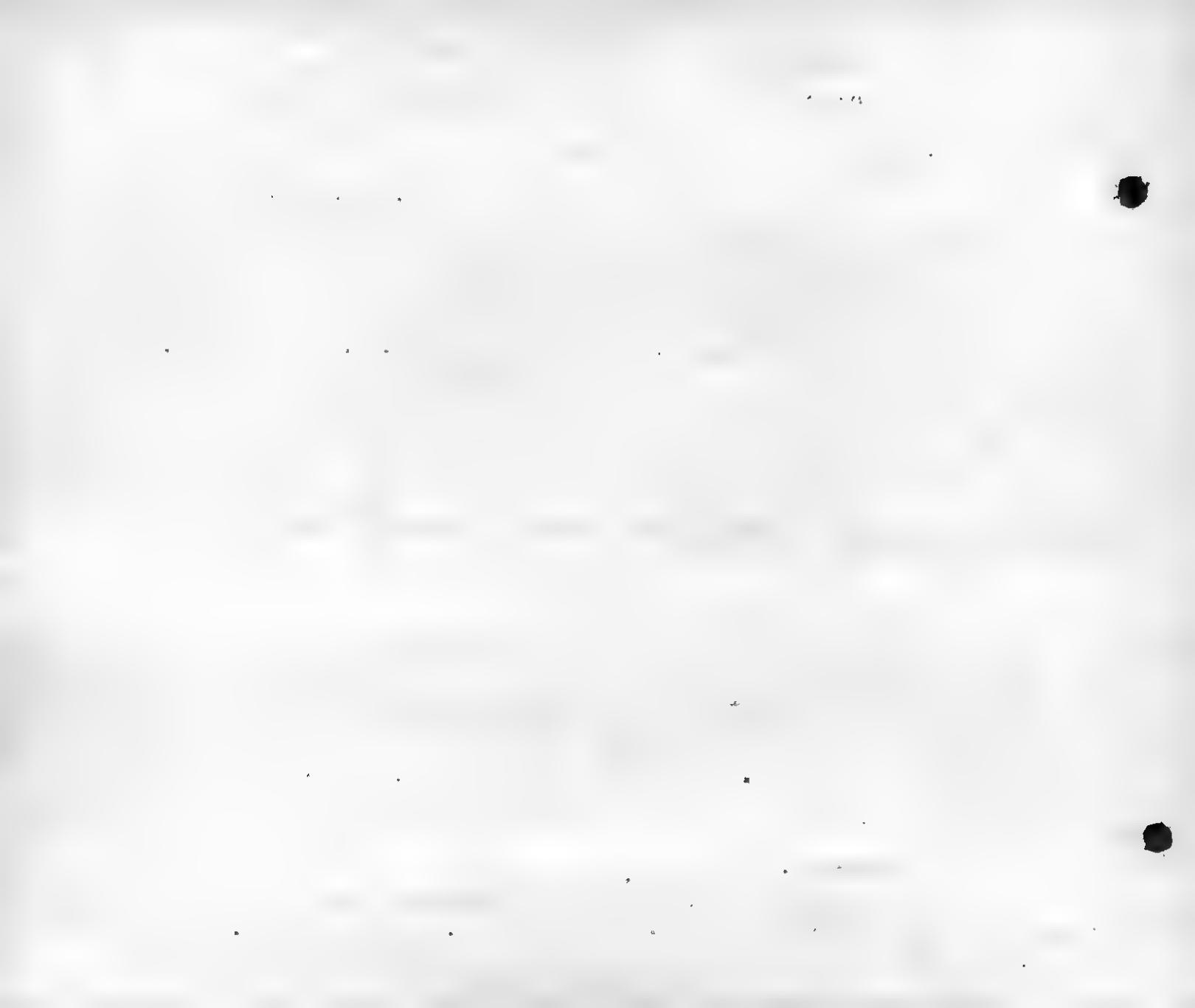
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10147

10172

CERTIFICATE OF DEATH

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Carroll | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton | | c. LENGTH OF STAY IN 1b 1,770 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | |
| 3. NAME OF DECEASED (Type or print) First Matthew | | d. STREET ADDRESS 31 N. Carey Street | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 4. SEX Male | | 5. COLOR OR RACE Negro | 6. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 7. DATE OF BIRTH 10-26-1909 | | 8. AGE (In years lost birthday) 50 yrs. | |
| 9. IF UNDER 1 YEAR Months Days | | 10. IF UNDER 24 HRS Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY SHIPYARD | |
| 10c. BIRTHPLACE (State or foreign country) Macon, N. C. | | 11. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Washington Towns | | 14. MOTHER'S MAIDEN NAME Mattie Mason | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO. 170-03-6416 | |
| 17. INFORMANT Matthew Towns - Patient | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Hemorrhage | | INTERVAL BETWEEN ONSET AND DEATH | |
| DUE TO Far advanced bilateral pulmonary tuberculosis | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. DUE TO (b) DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month Day Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from November 2, 1955, to September 15, 1960, that (I) (we) last saw the deceased alive on Sept. 15, 1960, and that death occurred at 10:00 P.M. from the causes and on the date stated above. | | 22b. DATE 9-15-60 | |
| 22c. SIGNATURE Edgars M. Maculans | | 22d. ADDRESS Henryton State Hospital, Henryton, Md. | |
| 23a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial | | 23b. NAME OF CEMETERY OR CREMATORIAL Baptist | |
| 23c. LOCATION (City, town or county) Baltimore | | (State) | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Charles Cooper | | 25a. REC'D BY REGISTRAR DATE 1960 | |
| ADDRESS 510 Parrottton Rd. | | 25b. REGISTRAR'S SIGNATURE Charles L. Krause | |

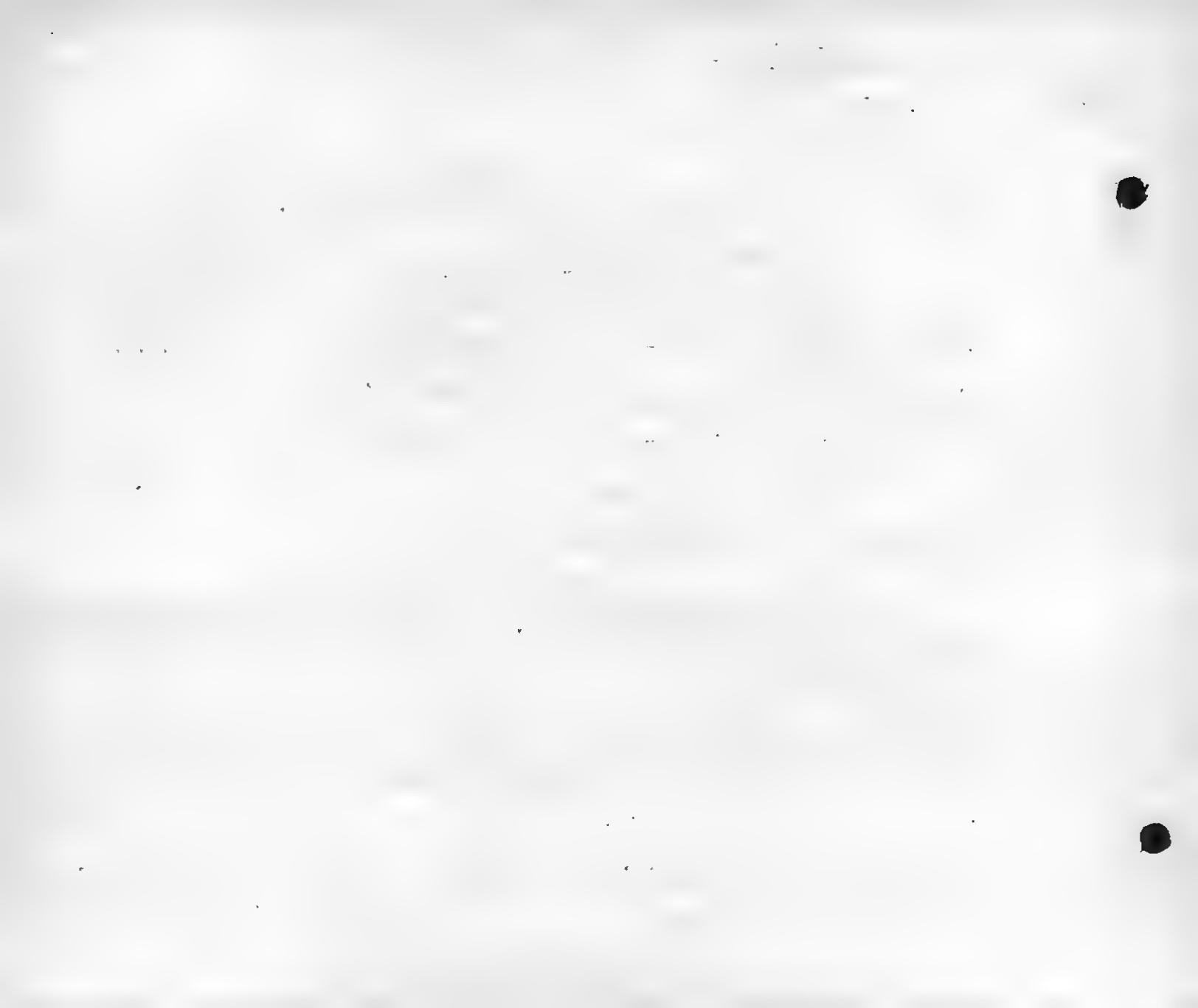


MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10148

CERTIFICATE OF DEATH

| | | | | | | | | |
|--|--|---|--|--|--|---|------------------------------------|---------|
| 1. PLACE OF DEATH a. COUNTY Carroll | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland | | b. COUNTY Washington | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville | | c. LENGTH OF STAY IN 1b 3 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown | | d. STREET ADDRESS 722 Oak Hill Ave. | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital | | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) Jeanette | | First | Middle | Last | 4. DATE OF DEATH September 25, 1960 | Month | Day | Year |
| 5. SEX Female | | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH Aug 1872 | 9. AGE (In years last birthday) 88 yrs | IF UNDER 1 YEAR Months | IF UNDER 24 HRS Hours | Min |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown Companion | | 10b. KIND OF BUSINESS OR INDUSTRY Unk - | | 11. BIRTHPLACE (State or foreign country) Unknown | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME Unknown | | 14. MOTHER'S MAIDEN NAME Unknown | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO 220-36-33504 | | 17. INFORMANT Springfield Hospital Records | | Address | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditons, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c) | | | | | | | | |
| Intestinal obstruction | | | | | | | | |
| Gangrenous inguinal hernia, right | | | | | | | | |
| PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerotic cardiovascular disease. | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | (County) | (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 9/23/60 19 to 9/25/60 19, that (I) (we) last saw the deceased alive on 9/25/60 19, and that death occurred at 1:45 PM from the causes and on the date stated above. | | | | | | | | |
| 22a. SIGNATURE | | M.D. | | ATTENDING PHYS. <input type="checkbox"/> | MED. DIRECTOR <input type="checkbox"/> | STAFF PHYS <input checked="" type="checkbox"/> | 22b. DATE SIGNED 9/25/60 | |
| 22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D. | | 22d. ADDRESS Springfield Hospital, Sykesville, Md. | | | | | | |
| 23a. BURIAL, CREMATION, APPROVAL (Specify) Burial | | 23b. DATE THEREOF 9-29-60 | | 23c. NAME OF CEMETERY OR CREMATORIUM St. John's | | 23d. LOCATION (City, town, or county) Ellicott City, Md. | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Funeral Height of Sykesville, Md. | | ADDRESS Funeral Height of Sykesville, Md. | | 25a. REC'D. BY REG. STAR SEP 28 1960 | | 25b. REG. STAR'S SIGNATURE Ellicott City, Md. | | |



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be read by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10149

| | | | | | |
|--|--|--|--|---|---------------------------------|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE | | | |
| Carroll | | MARYLAND | | b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. LENGTH OF STAY IN lb | | d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | |
| Rural - Sykesville | | 75 years | | Rural - Sykesville | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | e. STREET ADDRESS | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| | | Oklahoma Road | | | |
| 3. NAME OF DECEASED (Type or print) | | First | Middle | Last | 4. DATE OF DEATH |
| Male White | | RAY | W. | WARNER | Month Day Year |
| 5. SEX | | 6. COLOR OR RACE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH | 9. AGE (In years last birthday) |
| | | | | Sept. 3, 1881 | 79 yrs |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Actor | | Public Auction | | Md. | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| Wm. H. Warner | | Juliana Coppersmith | | U. S. A. | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO | | 17. INFORMANT | |
| No | | 215-05-1986 | | Mrs. Mandie B. Warner - Sykesville, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] | | Address | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | INTERVAL, BETWEEN ONSET AND DEATH | | | |
| 45.00 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause (st.) | | DUE TO (b) | Coronary Thrombosis, arteriosclerosis generalized, cardiac failure. | | 1955 to |
| | | DUE TO (c) | Arteriosclerotic heart disease. | | 6 Sept 60 |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | |
| 19 | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from _____ to _____, that (I) (we) last saw the deceased alive on _____, and that death occurred at _____ M, from the causes and on the date stated above | | 22b. DATE SIGNED 7 Sept 60 | | | |
| 22c. PHYSICIAN'S NAME (Type) | | 22d. ADDRESS | | | |
| Howard E. Hall | | Md. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF | | 23c. NAME OF CEMETERY OR CREMATORIUM | |
| Burial | | 9-9-60 | | New Oakland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | | 25a. REC'D BY REGISTRAR DATE SEP 9 '60 | |
| Arthur H. Haight Sykesville, Md. | | | | 25b. REGISTRAR'S SIGNATURE Arthur S. Knapp | |

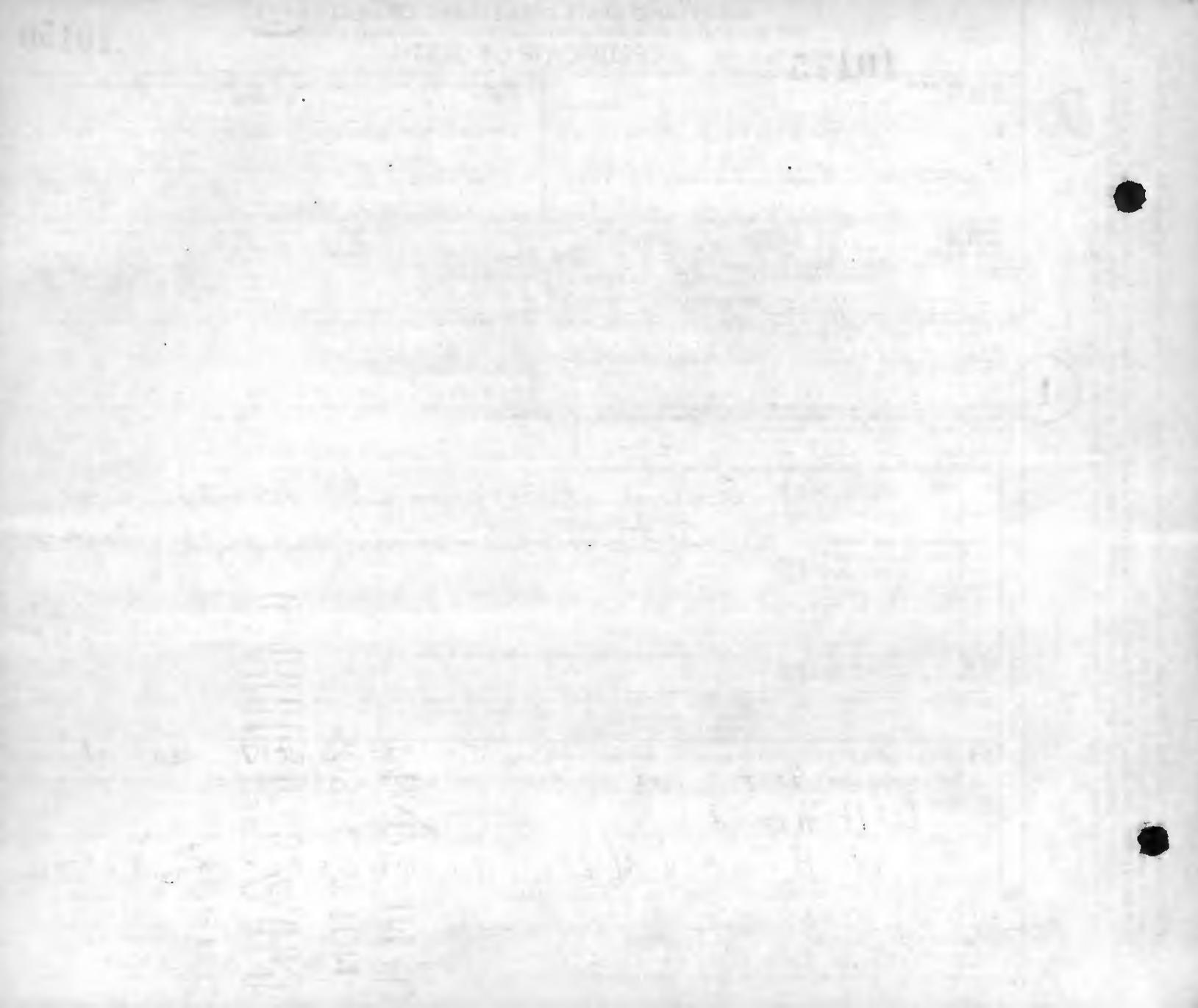


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10150

| | | | | | | | | | |
|--|--|--|---|---|---|---|--------------------|---------------|-----------------------------|
| 1. PLACE OF DEATH a. COUNTY | | CARROLL CO. MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTO. | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GREEN MOUNT | | c. LENGTH OF STAY IN 1b 1 yr. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION BASLER RD. | | Private home | | d. STREET ADDRESS W. CHESAPEAKE | | | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) | | First EMMA | Middle CORA | Last WEIL | 4. DATE OF DEATH SEPT. 17, 1960 | | | | |
| 5. SEX FEMALE | | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH JAN. 3, 1886 | 9. AGE (in years last birthday) 74 yrs. | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10b. KIND OF BUSINESS OR INDUSTRY OWN HOME | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | | | | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | | | | | | |
| 13. FATHER'S NAME WILLIAM RULLMANN | | 14. MOTHER'S MAIDEN NAME SARAH JANE MACKLEY | | Address | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. NONE | | 17. INFORMANT FAMILY RECORDS | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | Cerebral Hemorrhage (Recurrent) 5 Mos | | | | | | | |
| 331X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) | | Arteriosclerosis (generalized) 7 yrs | | | | | | | |
| DUE TO (c) | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Hour o. m. p. m. | | Month 19 | Day | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) BALTO. | (County) BALTO. | (State) MD | |
| 21. I certify that (1) (this hospital) attended the deceased from <u>June 15</u> , 1953, to <u>Sept. 17</u> , 1960, that (2) (we) last saw the deceased alive on <u>9-14</u> 1960, and that death occurred at <u>42</u> M, from the causes and on the date stated above. | | | | | | 22a. SIGNATURE W. H. Foard | | | 22b. DATE SIGNED 9-17-60 |
| 22c. PHYSICIAN'S NAME (Type) W. H. Foard M.D. | | M.D. | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | 22d. ADDRESS Manchester, MD 9-17-60 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF SEPT. 20, 1960 | | 23c. NAME OF CEMETERY OR CEMATORIAL BALTO. CEM. | | 23d. LOCATION (City, town, or county) BALTO., MD | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons, Towson, Md. | | ADDRESS | | 25a. REC'D BY REGISTRAR DATE SEP 21 '60 | | 25b. REGISTRAR'S SIGNATURE Charles S. Klaus | | | |



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10151

10176

CERTIFICATE OF DEATH

| | | | | | | | | | |
|--|--|--|--|---|---|--|-------------------------------|------------------------------|---------|
| 1. PLACE OF DEATH a. COUNTY Carroll | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland | | b. COUNTY Balto. City | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville | | c. LENGTH OF STAY IN 1b 11 mos. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 14 | | 3 VOI-4 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital | | d. STREET ADDRESS 511 Rossiter Ave. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) Mary | | First | Middle | Last | 4. DATE OF DEATH September 6, 1960 | Month | Day | Year | |
| 5. SEX Female | | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH March 9, 1877 | 9. AGE (In years last birthday) 83 yrs. | 10. IF UNDER 1 YEAR Months | 11. IF UNDER 24 HRS. Hours | 12. IF UNDER 24 HRS. Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress | | 10b. KIND OF BUSINESS OR INDUSTRY - | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME William H. Heim | | | | 14. MOTHER'S MAIDEN NAME Anna Kauffman Little | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 213-03-5936 | | 17. INFORMANT Springfield Hospital Records. | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 594X Senile atrophy of the kidney | | | | | | | | | |
| DUE TO | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) | | | | | | | | | |
| DUE TO | | | | | | | | | |
| (c) | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) C.B.S. assoc. with senile brain disease without qualifying phrase. Decubitus ulcers. | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) | (State) |
| 21. I certify that (I) (this hospital) attended the deceased from Oct. 7, 1959, to Sept. 6, 1960, that (I) (we) last saw the deceased alive on September 5, 60, and that death occurred at 6:10 AM, from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE Agustin del Campo | | M.D. | | ATTENDING PHYS. <input type="checkbox"/> | MED. DIRECTOR <input type="checkbox"/> | STAFF PHYS. <input checked="" type="checkbox"/> | 22b. DATE SIGNED 9/6/60 | | |
| 22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D. | | 22d. ADDRESS Springfield Hospital, Sykesville, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF 9-8-60 | | 23c. NAME OF CEMETERY OR CREMATORIUM Loudon Park Cemetery | | 23d. LOCATION (City, town, or county) Baltimore | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street | | ADDRESS | | 25a. REC'D BY REGISTRAR DATE SEP 8 '60 | | 25b. REGISTRAR'S SIGNATURE Curtis L. Krause | | | |

